COMPASSION-FOCUSED THERAPY FOR INDIVIDUALS WITH ANTENATAL MENTAL HEALTH DIFFICULTIES: A HERMENEUTIC SINGLE-CASE EFFICACY DESIGN (HSCED) SERIES.

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Thesis Abstract

Background: Perinatal mental health difficulties (MHD) affect between 10-20% of women in the United Kingdom (Bauer, Parsonage, Knapp, Iemmi, & Adelaja, 2014). Guilt and shame are now recognised as major contributors to a range of MHD (Gilbert, 2009; Gilligan, 2003) and frequently occur in new mothers, for example, due to concerns around motherhood 'performance' (Beck, Emery, & Greenberg, 1985), heightened responsibility (Oluyori, 2014), and societal expectations of a 'good mother' (Sutherland, 2010). However, this may be particularly prevalent in women experiencing clinical antenatal disorders (Beck & Barnes, 2006) due to fear of social services involvement arising from MHD and feeling shamed by society for not adhering to expectations of motherhood (Maimon, 2012). Guilt and shame can worsen symptoms of MHD due to the individual feeling unable to disclose symptoms and seek support during this time (Dennis & Chung-Lee, 2006). Compassion-Focused Therapy (CFT) is an integrative therapeutic model which emphasises affect regulation (Gilbert, 2005) and attachment principles (Bowlby, 1969). CFT attempts to reduce psychological distress by increasing compassion and reducing guilt and shame which often manifest as self-criticism (Gilbert & Miles, 2000). As CFT has a unique focus on the soothing Oxytocin system, it is particularly relevant in reducing maternal distress and positively impacting the mother-infant relationship (Cree, 2015) due to enabling attachment and bonding (Galbally, Lewis, Ijzendoorn, & Permezel, 2011).

Method: This report starts with a systematic literature review exploring the experiences of women who have had postnatal psychosis, in order to gain a new understanding of the effects of this mental health difficulty. This report then details a study which employed an adjudicated hermeneutic single-case efficacy design series (HSCED; Elliott, 2002; Elliott et al., 2009) to investigate the effectiveness of CFT for antenatal women with MHD. This intended to answer three aims: (i) is there evidence of substantial change following a six week CFT intervention? (ii) are changes attributable to therapy processes, common

factors, or other non-therapeutic explanations? (iii) are therapeutic processes CFT-specific?

Three adult pregnant women with MHD were recruited from a National Health Service (NHS) community perinatal service and engaged in six individual sessions of CFT. A range of quantitative and qualitative clinical data were collated ('rich case records'), which included outcome measures, CFT-specific measures, and a participant change interview. The rich case studies were critically analysed by three independent clinical psychologists ('judges') who provided opinions regarding whether the client changed, whether change was due to therapy, and whether CFT-specific or generic therapeutic factors were most influential.

Results: According to the judges' opinions only one participant changed at least 50% (ranging from 50-80% change). The judges generally believed change was more likely due to therapy than extra-therapeutic factors. The majority opinion was that any participant change was more likely due to generic or common factors, rather than CFT-specific factors. Helpful generic therapeutic factors included mindfulness practice, formulation, psychoeducation, and therapist attributes.

Discussion: It is inconclusive whether six sessions of individual CFT are effective in reducing distress for antenatal women. CFT-specific measures did not consistently reflect subsequent changes in outcome measures, suggesting that CFT-specific processes were not predominantly responsible for any positive client change.

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Statement of Contribution

Contribution	Contributors
Project design	Sophie Wicks; supervised by Dr David L Dawson and Dr Sarah Wilde, with initial guidance from Dr Vanessa Dale-Hewitt.
Applying for ethical approval	Sophie Wicks; supervised by Dr David L Dawson and Dr Sarah Wilde, with initial guidance from Dr Vanessa Dale-Hewitt.
Literature review and write up	Sophie Wicks; supervised by Dr David L Dawson and Dr Sarah Wilde, with initial guidance from Dr Vanessa Dale-Hewitt. Dr Katie Bohane provided guidance in consideration of clinical implications.
Recruiting participants	Initially identified and assessed by Dr Katie Bohane and NHS community perinatal team, contacted by Sophie Wicks.
Data collection	Sophie Wicks and Dr Vanessa Dale-Hewitt formed the participant demographic sheet and participant information sheets. Dr Vanessa Dale-

	Hewitt assisted in selecting psychometric measures. Sophie Wicks administered research intervention and collected data, supervised weekly by Dr Katie Bohane and fortnightly by Dr David L Dawson. Sophie Wicks arranged practicalities such as GP room bookings, with advice from Dr Katie Bohane and NHS community perinatal team administration staff. Andrew Reeve conducted change interviews with participants.
CFT protocol	Sophie Wicks delivered the CFT intervention. Dr Vanessa Dale-Hewitt and Sophie Wicks formed the CFT protocol. Dr Catherine Hawkins reviewed the CFT protocol. Members of the Open House group reviewed the CFT protocol.
Scoring questionnaires	Sophie Wicks scored the questionnaires. Dr Nima Golijani-Moghaddam provided recommendations regarding scoring of the PQ and CORE-5. Professor Michael Barkham provided guidance on scoring the CORE-5.

Data analysis	Dr David L Dawson assessed CFT intervention fidelity and working alliance. Dr David L Dawson assisted in reviewing rich case records and considering aspects of affirmative and sceptic cases, which were developed by Sophie Wicks. Dr Mark Gresswell, Dr Thomas Schröder, and Dr Nima Golijani-Moghaddam reviewed case summaries and provided judicial reports whilst acting as independent psychotherapy 'judges' as part of data analysis. Dr David L Dawson and Dr Sarah Wilde read drafted sections of the write-up.

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A meta-synthesis exploring the experience of postpartum psychosis.

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Abstract

Background: Little research exists regarding postpartum psychosis, in comparison to other perinatal mental health disorders such as postpartum depression.

Methods: A meta-ethnography utilised twelve qualitative studies.

Results: Four themes were developed: support needs and preferences; the terrifying and surreal world of postpartum psychosis; stigma and dismissal and; process of recovery.

Conclusions: Alongside the four themes identified, consideration of personal appraisals and regaining personal identity may assist with recovery. Women and their families should be part of decision-making and provided with appropriate information throughout treatment. Discourses surrounding postpartum psychosis require particular consideration to avoid stigma and promote early help-seeking.

Keywords: meta-ethnography, experience, postpartum psychosis, qualitative, interviews, puerperal psychosis

Introduction

Postpartum[2] psychosis is considered by health professionals as "the most serious perinatal mental disorder" and a debilitating medical emergency requiring urgent admission (Heron et al., 2012). It most commonly develops within 48 hours to two weeks following childbirth (Doucet et al., 2012) and is experienced by approximately one in every 1000 women in the United Kingdom (UK; Monzon et al., 2014). Postpartum psychosis shares symptoms with 'psychotic disorders', as defined by the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) as "abnormalities in one or more of five domains: delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behaviour, and negative symptoms" (American Psychiatric Association; APA, 2013). However, with swift, efficient treatment, the prognosis for most women is encouraging, with recovery often occurring within a few weeks (Jones & Smith, 2009) although many women report that it may take at least one year to feel 'fully recovered', often longer (Sit et al., 2006).

Postpartum psychosis is not currently a diagnostic category in the DSM-V (APA, 2013) or the International Classification of Diseases (ICD10; World Health Organisation, 1992) but the term remains prevalent in public and professional domains (Jones & Cantwell, 2010). A continuum model of psychosis has been proposed, suggesting that symptomology is also prevalent to varying degrees amongst non-clinical populations (Mannion & Slade, 2014). This suggests that many individuals experience symptoms but are considered sub-clinical due to lack of resulting distress (Bentall, 2003). Additionally, anxiety often increases throughout pregnancy (Newham & Martin, 2013), which may support a stress-vulnerability model (Zubin & Spring, 1977) for postpartum psychosis. Combined with the woman's environment and emotional experiences (Hooley, 2007), this may provide further understanding as to the development of postpartum psychosis.

[2] Also referred to as 'puerperal', 'postpartum' and 'postnatal'

Psychotic experiences often reflect personal and social context, for example, with relation to personal goals, stress-inducing events, wider societal pressures or events, unmet expectations of motherhood, or a perceived lack of control (Rhodes & Jakes, 2000). Within postpartum psychosis, the content of psychotic experiences often concerns the infant, for example, beliefs that the infant is not theirs or is inhuman (Stein, 1998). Such beliefs may attract significant stigma and/or shame, given societal discourses regarding maternal instincts and the celebration of birth. It is therefore important for clinicians, women experiencing postpartum psychosis, and families, to have knowledge and understanding of the content of beliefs within postpartum psychosis to inform its management and treatment.

There has been limited research of postpartum psychosis in comparison to the literature surrounding postpartum depression[3] (Cox et al., 1993). To date, research has largely focussed on biomedical aspects, emphasising clinical symptoms, diagnosis, and generating quantitative comparisons with non-perinatal psychosis (Robertson & Lyons, 2003). Less focus has been placed on the women's accounts of the experience, despite "first-person accounts" being valued within broader psychosis research due to their potential to increase empathy and compassion, reduce stigma, and generate hope (Mowbray et al., 1998).

Effective treatment is essential in supporting recovery, yet the relative scarcity of literature highlights the need for deeper exploration of the experience of postpartum psychosis to influence and specify psychological recommendations, as per other postpartum disorders such as postpartum anxiety and postpartum depression. Whilst medicinal and other medical interventions are pivotal, without adequate psychological and practical support, there are likely negative repercussions for the mother-infant relationship (Bågedahl-Strindlund & Ruppert, 1998), mother-partner relationship (Engqvist & Nilsson, 2011), and ability to care for other children (Bågedahl-Strindlund, 1987). In some cases,

[3] Postpartum depression affects 10-15% of women, whereas only 1-2% are diagnosed with postpartum psychosis in the UK each year (Cox, Murray & Chapman, 1993).

inefficient care may result in suicide, accidental harm to the child, and in some rare, tragic cases, infanticide (the intentional killing of an infant; Spinelli, 2004). Additionally, more specificity regarding psychological intervention may decrease use of anti-psychotic medication where appropriate as side effects can be harmful, particularly when the mother is breastfeeding and the infant may also be affected (Klinger, Stahl, Fusar-Poli, & Merlob, 2013).

Researchers recognise the necessity of furthering understanding women's experiences of postpartum psychosis (Doucet et al, 2012; Engqvist, 2011). Synthesising the qualitative research regarding the experiences of the women themselves is one way in which the understanding of this phenomena can be developed. A more comprehensive understanding is likely to benefit women and their support networks, including health professionals, family members and partners. Few qualitative papers have explored women's experiences of postpartum psychosis but those that have cover a range of related issues, including key aspects of the recovery process (McGrath et al., 2013), perceived cause (Robertson & Lyons, 2003), support needs (Doucet et al, 2012), and the experience more broadly (Engqvist & Nilsson, 2011). A synthesis of qualitative studies can go beyond the findings of individual qualitative study (Campbell et al., 2003) to develop knowledge about a phenomenon.

Meta-ethnography (Noblit & Hare, 1988) is an interpretative method which synthesises findings across qualitative research papers to provide advanced analysis, understanding, and scope for future research questions (Finfgeld, 2003). This involves researching existing papers and synthesising (combing and interpreting) their results to produce overarching findings (Atkins et al., 2008). Although meta-synthesis has attracted criticism for synthesising tentative papers of differing qualities, it offers opportunity for new insights and approaches to emerge.

Aims of this review

The first aim of this paper is to systematically locate and critically appraise relevant qualitative research regarding the experience of postpartum psychosis.

The second aim is to use a meta-ethnographic approach to synthesise the findings of identified papers and answer the research question, “what is the experience of having postpartum psychosis?” The question was purposefully broad as initial searches identified relatively few studies in the field, with varied foci.

Method

The review involved three stages: a systematic search of available literature; critical appraisal of relevant studies and; a meta-ethnographic synthesis using the process described by Noblit and Hare (1988). A critical realist perspective was adopted throughout this paper. This approach acknowledges that individuals make sense of their experience and ‘reality’ in different ways (Bhaskar, 1989). Additionally, socio-cultural experiences mediate access to this reality and allow transparency of the researcher’s and participants’ interpretative resources (Smith, 2015).

Searching

Initial searches highlighted limitations in obtaining research focusing on specific elements of postpartum psychosis. The research question was subsequently reviewed and specified with use of an adapted ‘population-intervention-comparison-outcome’ (PICO) table (Boland et al., 2013) and research protocol (Boland et al., 2013). The PICO table is a tool used to assist the author in defining the clinical question which forms the basis of the literature search.

A systematic search was undertaken on March 18, 2019. Four electronic databases were searched due to providing comprehensive coverage of relevant

research across peer-reviewed journals, and proven efficiency in previous systematic literature reviews (Wright et al., 2015).: Medline (1946-present), PsycINFO (1806-present), Scopus (1960-present), Cumulative Index to Nursing and Allied Health Sciences (CINAHL; 1981-present). Ethos and OpenGrey were searched to limit the risk of excluding potentially relevant, rich unpublished data (Evans, 2002), and the British Psychological Society (BPS) database was searched as a specialist psychology database. A hand search was also implemented, which included 'back searching' (utilising references of relevant papers) and 'forward searching' (using Google Scholar to identify papers which cited relevant articles). Lastly, a specialist psychologist in the field of perinatal mental health was consulted to ascertain if any known papers had been missed.

Search terms

Search terms were developed from examining similar literature reviews and Cochrane reviews, consultation with the subject librarian, and via databases thesauruses/Medical Subject Headings (MeSH) and suggested search terms. Please see Appendix A. Truncation tools and Boolean searches were also implemented where possible to maximise searches. Search terms were adapted according to result adequacy and appropriateness. The following search terms were employed:

Postnatal Psychos?s, Postpartum Psychos?s, Puerperal Psychos?s, experience?, Birth N5 Psychos?s, Perception?, View?, Attitude?

Selection

Papers were included if they:

(1) Were original research into the first-person perspective of having postpartum psychosis.
(2) Used recognised qualitative methodology, including participant quotations.
(3) Included participants aged 18 years or older.
(4) Were published in English.

Papers were excluded if they:

(1) Were mixed methods papers where qualitative component could not be independently extracted.
(2) Contained mixed person accounts where first-person account could not be independently extracted.
(3) Described multiple perinatal disorders, yet findings with regards to postpartum psychosis could not be independently extracted.

One paper[4] was inaccessible after request through the database, university, inter-library loan, and contacting the author. Please see Appendix B.

Analysis

Data abstraction

Papers were read, re-read, and relevant data identified using a data extraction tool, which informed quality appraisal of papers, and synthesising findings.

Synthesis of findings

This interpretive method of synthetization proposes a deeper level of understanding, as opposed to other reviews which merely provide a "basic comparability between phenomena" (Noblit & Hare, 1988, p.15). Noblit and Hare (1988) describe three methods of synthesis which were employed within this review: reciprocal translations of themes from one study to another (what themes do the papers have in common?); refutational synthesis (what differences in findings between studies exist?) and; the line-of-argument synthesis, through which the synthesis is described and new understandings are offered

Within metasynthesis, it has become common to think about the distinction between first, second and third order constructs. 'First-order constructs' refers

[4] Unpublished thesis - "Putting together the jigsaw puzzle: Women's sense of self following an episode of postpartum psychosis" (O'Brien, 2011).

to direct participant quotes within included studies. ‘Second order constructs’ are the interpretations of the authors of included studies, i.e. usually found in the ‘results’ section of papers. ‘Third order constructs’ are the synthesist’s interpretations of both first- and second-order constructs, i.e. the themes constructed through the process of the synthesis.

Quality appraisal

Debate exists surrounding use of critical appraisal within meta-synthesis. Some professionals describe critical appraisal as a useful tool for determining inclusion/exclusion of studies, whilst others view it as an interpretative tool for developing exploration and insight (Spencer et al., 2003). There is a lack of consensus on preferred, ‘gold standard’ criteria for critically appraising qualitative research (Walsh & Downe, 2005). Subsequently, an adapted Critical Appraisal Skills Programme (CASP; Public Health Resource Unit, 2010) tool was used in this paper to determine quality of research papers included. The CASP tool provided prompts for consideration across each broad domains of research e.g., method used, how findings represented, to assess the ‘quality’ of each research paper.

Criteria were added regarding epistemological position (the way the author views the pursuit of knowledge), consideration of diagnosis of postpartum psychosis, and length of time between the episode of psychosis and recall of it by the participant in the research. Criteria regarding diagnosis and length of recall were deemed important after speaking to a specialist perinatal clinical psychologist and researching these aspects further, due to an increase in reliability and validity of the research if adequately considered and standardised.

Scores of zero, one, and two were given to indicate whether criteria were unmet, partially met, or fully met. This provided a clear total score for each paper. The stance taken was acknowledging importance of ascertaining quality and ‘weighting’ of studies within the review, yet recognising all research provides important findings in this field (Sandelowski et al., 1997). No papers were excluded on the basis of the quality appraisal.

Reflexivity

The process of meta-synthesis is subjective and shaped by the researchers' own experiences, position and perspective (Noblit & Hare, 1988). As this cannot be completely eradicated, transparency is crucial in ensuring quality of the synthesis (Finlay, 2006). This 'transparency' may include aspects such as the age of the researcher and their personal experiences, which will likely impact the way they interpret the research papers. The researchers strongly believe that the public and other professionals should be more aware of the experience of postpartum psychosis, including treatment and recovery. They believe it is important to aid women to have their voices heard, whilst diminishing stigma and misconceptions associated with postpartum psychosis. Consideration was given to the urge to align with the mothers' views over alternative views, for example those that might give primacy to the child, family members, or issues of risk. The first author became aware of a negative bias towards papers which were perceived to be stigmatising women.

To minimise bias and expectations, it was important to remain open-minded and include papers which discussed potentially 'unusual' or unexpected aspects of the experience. During synthesis, refutational (conflicting) accounts were purposely given careful consideration, and potential third order constructs were discussed within supervision (Toye et al., 2013). Papers were also discussed in a workshop for peers interested in meta-synthesis, which allowed consideration of others' interpretations of the data. It was also critical to ensure proposed themes were supported by first order constructs (original data) and overall data (Toye et al., 2013).

Results

Study selection

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher et al., 2009) was implemented as a framework for paper selection. This process is described in Figure 1.

The twelve included studies were conducted between 2002 and 2016, with nine studies occurring in the UK, one in Sweden, one within the United States of America and Canada, and one study was unclear on location (3). Please see Table 1 for further information regarding paper characteristics

Table 1.
Paper characteristics

Study	Author, year, location	Research title	Qualitative methodology utilised	Number of participants and recruitment strategy	Data analysis method
1	Engqvist & Nilsson. 2013. Sweden.	Experiences of the first days of postpartum psychosis: An interview study with women and next of kin in Sweden.	Face-to-face interviews.	Advertised by author on a radio station. Utilised network 'Swedish Patients Association.' Snowball sampling via participants contacting other women they met with postnatal psychosis. Advertised via article in a mental health journal. 13 participants.	Content analysis.

2	Heron et al. 2012. UK.	Information and support needs during recovery from postpartum psychosis.	Face-to-face interviews.	Via network 'Action on Postpartum Psychosis' (APP). 5 participants.	Grounded analytic induction.
3	Robertson & Lyons. 2003. Unclear location.	Living with puerperal psychosis: A qualitative analysis.	Face-to-face interviews.	All participants had previously taken part in related research and agreed to be contacted in event of further research. An advert in a mental health newsletter was also utilised. 10 participants.	Grounded theory.

4	Chotai. 2016. UK.	Postpartum psychosis and beyond: Exploring mothers' experiences of postpartum psychosis and recovery.	Face-to-face interviews.	Advertising via online forums and social networking sites linked with charities that support women with postnatal psychosis. 8 participants.	Interpretative phenomenological analysis.
5	Glover, Jomeen, Urquhart, & Martin. 2014. UK (North England).	Puerperal psychosis - a qualitative study of women's experiences.	Face-to-face interviews.	Recruited via a local specialist psychiatry service for mothers and babies in North England. 7 participants.	Thematic analysis.
6	Hunter. 2013. UK.	Postpartum psychosis: A Foucaldian analysis	Interviews (unspecified whether face-to-face)	Advertisement posted by an online	Foucauldian discourse analysis.

		of women's experiences living with this diagnosis.		Postpartum Psychosis Charity Network. Some participants recruited through making contact with key researcher in area of qualitative research in postnatal psychosis. 10 participants.	
7	Day. 2002. UK (London).	A qualitative analysis of women's accounts of puerperal psychosis and postnatal depression: the search for similarity,	Face-to-face interviews.	Mother and baby unit in London. 3 participants.[5]	Interpretive phenomenological analysis.

[5] This study recruited six participants in total, but three had postnatal psychosis.

		difference and understanding.			
8	Doucet, Letourneau & Blackmore. 2012. USA and Canada.	Support needs of mothers who experience postpartum psychosis and their partners	Face-to-face and telephone interviews.	Variety of community and hospital agencies that provide services for mothers in postpartum period. 9 participants.	Thematic analysis.
9	McGrath, Peters, Wieck & Wittkowski. 2013. UK.	The process of recovery in women who experienced psychosis following childbirth.	Face-to-face and (one) telephone interview.	Recruited via a mother and baby unit in North-West England. Advertisements placed on website forums and newsletters for women with experience of postnatal psychosis.	Grounded theory.

				12 participants.	
10	Plunkett, Peter, Wieck & Wittkowski. 2016. UK (England).	A qualitative investigation in the role of the baby in recovery from postpartum psychosis.	Face-to-face and telephone interviews.	A mother and baby unit in England. Advertisement on website forums for mothers who have experienced postpartum psychosis. 12 participants.	Thematic analysis.
11	Wyatt, Murray, Davies & Jomeen. 2015. UK (England)	Postpartum psychosis and relationships: their mutual influence from the perspective of women and significant others.	Face-to-face interviews.	NHS perinatal mental health services and online via social media and Action on Postpartum Psychosis website.	Interpretive phenomenological analysis.

				7 dyads, 14 participants.	
12	Stockley. 2018. UK (England and Wales)	Women's experiences of postpartum psychosis during the onset and early days.	Face-to-face interviews.	Action on Postpartum Psychosis Facebook page. 7 participants.	Interpretive phenomenological analysis.

Critical appraisal

The quality of papers was variable, ranging from a total score of 11-21, and explicit points for consideration published by CASP qualitative research criteria were used to assign points. Papers were appraised by two authors in an effort to increase reliability of scoring. It should be noted that unpublished theses are not constrained by editor preferences and strict word counts, which may account for higher quality scores as they are able to include more detail. Please see Table 2 for a summary of findings.

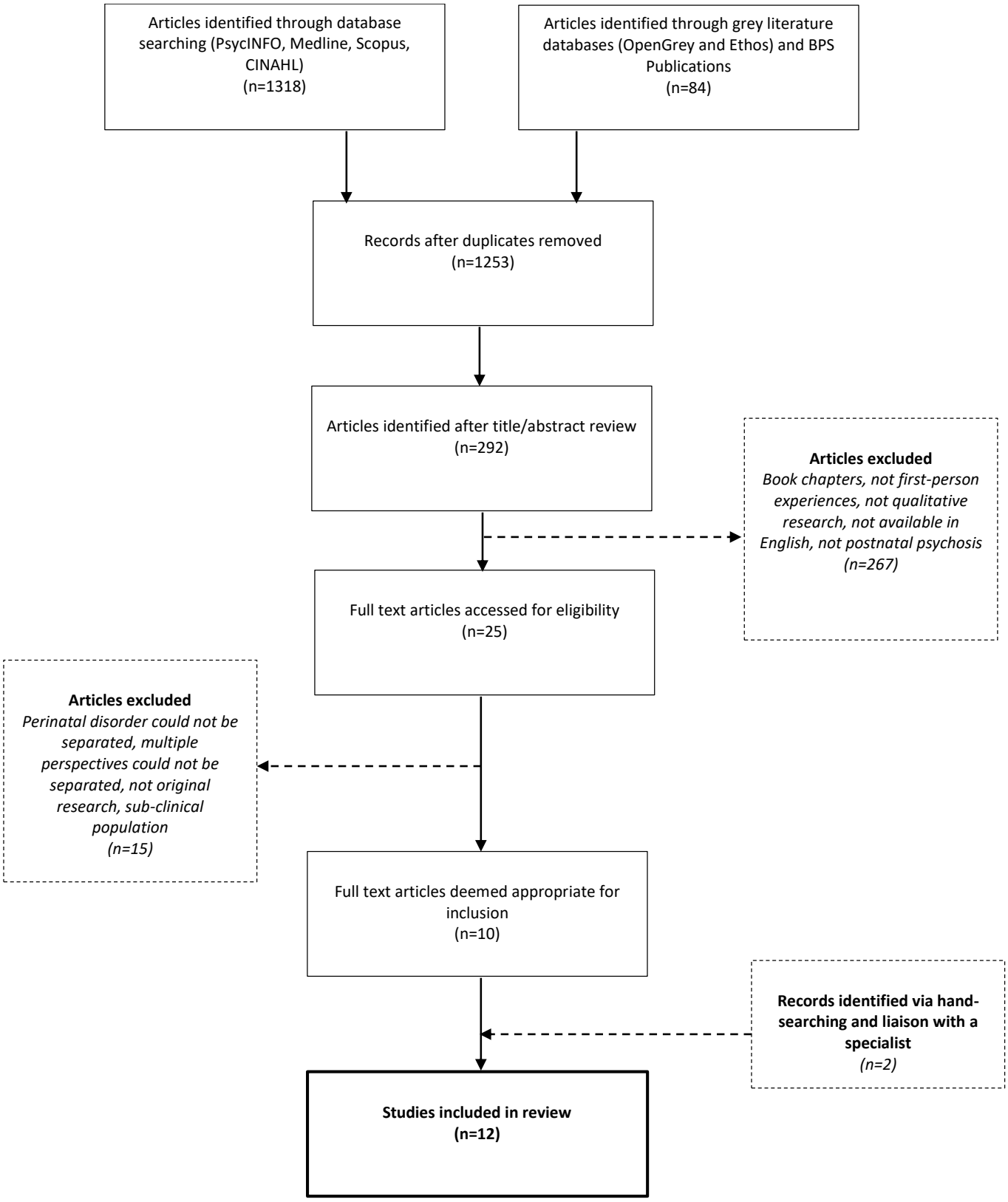

Figure 1. Flowchart outlining process of article selection

It was not presence of bias, but rather transparency regarding potential bias by researchers, which was appraised, and therefore explicit consideration of the impact of the researcher on the study, participants, and analysis, was imperative (Jootun et al., 2009). However, only three studies fully met criteria regarding researcher bias or consideration of reflexivity (6,9,12), whilst another five studies partially met this criteria through brief reference (3,4,7,10, 11). Five papers (4,6,7,9,12) stated their epistemological position.

Overall strengths within research papers included appropriate use of methodology (semi-structured interviews), clearly stated research aims, clear rationale for research design (except 6), data provided to support second order constructs (suggested by original authors), and clear third order constructs.

Overall weaknesses across papers included: not justifying choice of research design which led to eleven studies only partially meeting this criteria (except 6); lack of data regarding participant demographics (exceptions 4,6,7,9,11); inadequate consideration of ethical issues (except 6,12); variable time elapsed since episode (except 7); adequate discussion of the evidence both for and against the researcher's arguments and discussion of credibility of findings (except 1,4,5,6,9,10,11); little exploration of contradictory findings and researcher bias (exceptions 2,3,7,8,12) and; lacking rigorousness of diagnosis (exceptions 5,7,9). Time elapsed since episode collectively ranged from 1-32 years. Memory is variable over this period of time and may become distorted and therefore unrepresentative (Collins et al., 1995). Conversely, one paper (1) suggested that due to the intensity of this life-changing experience, women are likely to recall details accurately. However, this may be questionable given the perceptual difficulties that are inherent for individuals experiencing psychosis. Study (7) provided findings in multiple complex tables, and headings did not consistently match table descriptions, which impaired understanding. One study (5) presented second order constructs that at times appeared to have more overlap than distinction, with subthemes that did not clearly connect to overarching themes. This led to aspects of their second order themes being

synthesised under third order constructs with which there was a more obvious connection. One paper (11) had much overlap between themes and three themes were not distinctly different from each other. Another study (7) listed multiple causes concerning the over-arching theme of ‘explanations for distress,’ yet did not differentiate between causes of distress and causes of postpartum psychosis. The assumption that these causes are correlated and comparable is inconsistent with current research (Bentall, 2003).

Six studies justified the recruitment strategy and considered limitations, including potential bias (3,4,6,8,9,10). Two studies (2,7) recruited from one service but did not justify or critique this. Three studies (1,11,12) did not adequately justify or critique their recruitment strategy, and one study (5) did not explain why seven individuals were excluded from participating. Few papers critiqued the role of ‘gatekeepers’ (professionals who had the power to suggest or deny potential participants from taking part either directly or due to the level to which they promoted the research study) during the recruitment strategy, or other potential biases resulting from the recruitment strategy (e.g., only recruiting from one service).

Table 2.
Critical appraisal of studies included in review

CASP Criteria	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Clear statement of aims?	2	2	2	2	2	2	2	2	2	2	2	2
Qualitative methodology appropriate?	2	2	2	2	2	2	2	2	2	2	2	2
Research design appropriate to aims?	1	1	1	1	1	2	1	1	1	1	2	1
Recruitment strategy appropriate to aims?	1	1	2	2	1	2	1	2	2	2	1	2
Data collected in a way that addressed the research issue?	1	1	2	2	2	2	2	1	2	1	1	1
Relationship between researcher and participants adequately considered?	0	0	1	1	0	2	2	0	2	1	1	2
Ethical issues taken into consideration?	1	1	1	1	1	2	0	1	1	1	1	2
Data analysis sufficiently rigorous?	1	1	1	2	1	2	2	1	2	1	2	1
Clear statement of findings?	2	1	1	2	2	2	1	1	2	2	2	1
Epistemological position stated?	0	0	0	2	0	2	2	0	2	0	0	1
Diagnosis checked and critiqued?	0	1	1	1	2	1	2	1	2	2	1	1
Length of time between episode and recall adequate and critiqued?	1	1	1	0	1	0	2	1	1	1	1	1
Total score	*12*	*12*	*15*	*19*	*15*	*21*	*19*	*13*	*21*	*16*	*15*	*17*

Synthesis

Themes across papers were not in direct opposition but offered a range of explanations. Table 3 summarises third order construct themes and subthemes resulting from the synthesis. Overarching themes were: the terrifying and surreal world of postpartum psychosis; stigma and dismissal; support needs and preferences and; process of recovery. These are described below, alongside supporting evidence from first order data and second order constructs.

Table 3.

Cross comparison of third order constructs

Third order *themes* and subthemes	1	2	3	4	5	6	7	8	9	10	11	12
The terrifying and surreal world of postpartum psychosis	*	*	*	*	*	*	*	*	*	*		*
Suicidal and infanticidal ideation	*			*								
Distress	*	*	*	*	*		*	*	*	*		*
Unmet expectations	*	*	*	*		*	*	*				
Stigma and dismissal	*	*	*	*	*	*	*	*	*	*		*
Support needs and preferences	*	*	*	*	*	*	*	*	*	*	*	
Postpartum psychosis seen as different from other mental illnesses	*	*	*		*							
Contact with professionals	*	*	*	*	*	*	*	*	*	*		
Contact with non-professionals	*	*	*	*	*		*	*	*	*	*	
Importance of information		*	*							*		
Process of recovery	*	*	*	*		*		*	*	*	*	
The role of the infant	*								*	*		
Regaining and developing personal identity	*	*	*	*		*		*			*	

Note: * indicates which papers contributed to each theme and subtheme.

The terrifying and surreal world of postpartum psychosis.

All but one paper (11) described participants' experiences as terrifying and distressing. A combination of confusion, fear, psychotic symptoms, and overwhelming emotions existed.

Suicidal and infanticidal ideation. Two papers (1,4) referenced women discussing suicidal and infanticidal ideation during their experience. However, reasons for this differed between participants. One woman described contemplating 'altruistic suicide':

[…] my own voice […] it was commanding myself to do things and if I didn't do these things then it would mean I was selfish and it would cause harm to others. So if I didn't kill myself […] then my family would die." (Chotai, 2016, p.66).

Conversely, others stated they wished to die for relief from the hopeless darkness. Some stated that family members, but not the infant, were a protective factor. One woman described not wanting to die but feeling unable to continue living due to this new life she was living:

[…] I knew it was not the person I really am. It just felt it was too bad. I missed the person I am and the person I recognised as me. (Engqvist & Nilsson, 2013, p.87).

Similarly, reasons for infanticidal ideation differed between participants. For some, this thought was intrusive and attributed to the psychosis, for others the infant was strongly aversive and caused resentment. A third motivation for contemplating infanticide was to save the infant:

[…] it was a bad world. It was not a good place to be. I wanted to protect my children from this. Then I thought "Well, I'll kill them." (Engqvist & Nilsson, 2013, p.86).

For some women, these intrusive thoughts were unacceptable and intolerable, which made disclosure difficult:

[…] I certainly wouldn't tell anyone those thoughts unless they had been through it. It's inconceivable really to think about harming your own child. (Hunter, 2013, p.55).

Some women were unwilling to speak about the nature of these thoughts, even many years post-episode.

Distress. The experience of postpartum psychosis led to an array of distressing emotions and cognitions, particularly surrounding guilt, shame, fear, and desolation. All but one paper (6) referenced the distress associated with the experience of postpartum psychosis. Guilt appeared to relate to the inability to care for the baby, reliance on loved ones, and 'missing out':

[…] all these feelings of guilt because you missed out (Heron et al., 2012, p. 157).

Many women described fear during this period, accompanied by powerful cognitions:

[…] I had a fear of everything, I was scared that I was going to die and nothing was normal and I feared everything (Chotai, 2016, p. 66).

In addition, one paper (12) highlighted the prevalence of worry about caring for the baby which was sometimes the start of a psychotic belief or delusion:

[…] That was the point when I had started to say something bad is happening or happened, or, erm, I think I have done something to my baby… I was like, I get it now. I have basically done something to Baby, she's died, so I have killed her (Wyatt, Murray, Davies, & Jomeen, 2015, p.153).

There was a strong emotional reaction to postpartum psychosis, and women experienced a sense of powerlessness, despair, and confusion. These emotions were accompanied by cognitions regarding feeling like a "freak", attempting to make sense of what was happening to them, comparing

themselves to their previous self and others, and thoughts of intentional harm. The emotional responses to infanticidal ideation differed according to intent and appraisal, with guilt and shame being responses to contemplation and planning, versus anxiety and despair in response to intrusive thoughts.

Unmet expectations. Multiple women felt frustrated about the mismatch between their own and others' expectations and the reality of motherhood. Seven of the studies (1,2,3,4,6,7,8) described participants feeling motherhood was not as expected, particularly when previously excited about the prospect:

> […] It's such a shock and at the time that you were expecting to be such a wonderful time (Heron et al., 2012, p. 157).

Some women felt pressurised and invalidated by societal and familial expectations. One study (6) explored this from a social constructivist perspective, considering the phrases used by the individual which suggested her experience of motherhood was 'wrong.' This was particularly evident when different generations' discourses surrounding motherhood did not 'allow' for mental illness:

> […] Pull yourself together don't you think I wasn't depressed but in 1960 we didn't allow for that. If I heard that once, I heard it a hundred times. (Glover et al., 2014, p. 261).

The experience of postpartum psychosis led to women not meeting perceived societal and individual pressures and expectations of motherhood, which led to distress when these were not met due to the experience of postpartum psychosis.

Stigma and dismissal.

Whilst navigating through the complexities of postpartum psychosis, many women described experiencing or fearing negative judgements from others. All but one paper (11) described experiences of stigma or dismissal, although some did not explicitly state whether these were actual or perceived by the women. However, this review acknowledges the differences between these

two experiences, whilst validating that both perceived and actual stigma is likely to result in distress. There was an assumption among participants that people would react negatively to women with postpartum psychosis, due to media portrayals and stereotypes:

[…] Everybody's worse nightmare in the world if they're very honest with you […] to be locked in an asylum or mental hospital because of the way it's portrayed on telly and the white coats and padded cells and stuff (McGrath et al., 2013, p.5).

Conversely, some women reported that they were able to successfully hide their mental health difficulties and appear healthy and well. This was reportedly a deliberate effort in order to avoid raising suspicion for fear of negative consequences or judgement:

[…] I looked the picture of health. You would not have thought I was ill. You'd go, she looks immaculate…I used to put makeup on as like my mask. I used to make myself immaculate (Stockley, 2018, p.155).

The reaction from friends and partners seemed to dramatically affect the trajectory of recovery. The avoidance of discussion perpetuated stigmatising experiences and was isolating when support was vital:

[…] It was just something that was…um…avoided, yeah. They wouldn't ask me how I was. It's like the whole stigma of mental illness mustn't be talked about (McGrath, et al., 2013, p.6).

Feeling dismissed and invalidated was particularly difficult when it had taken courage to disclose these experiences. Some women also felt dismissed by loved ones during a time they needed support most:

[…] You've only had a baby, what's wrong with you, why you acting like this? (Glover et al., 2014, p.261).

However, some reported feeling well-supported and understood by loved ones:

[…] the support of my family helped more than anything (Heron et al., 2012, p.161).

Many participants reported positive, integral contact with professionals who enabled a non-judgemental space to make sense of their experiences:

[…] Talking to the psychiatrist, cos you can tell her anything, no matter what you tell her she doesn't criticise you […] just being able to talk about how you're feeling (Day, 2002, p. 49).

Some participants also described the importance of empathy and support both within services and following discharge as crucial for those experiencing postpartum psychosis.

Support needs and preferences.

Considering the tremendous impact of postpartum psychosis, and the role of other people's reactions, many participants were keen to voice needs and preferences for support that could aid recovery. All papers contained accounts regarding this, which largely stemmed from both positive and negative experiences with professionals, services, and loved ones.

Postpartum psychosis seen as different from other mental illnesses. Four studies (1,2,3,5) described participants' strong desire for postpartum psychosis to be seen as separate from other mental illnesses This appeared to manifest from two perspectives: postpartum psychosis requiring specialised treatment and support, and a desire for this disorder to be seen as separate from other mental illnesses. The latter perspective was not an explicit first order construct but inferred from language used:

[…] Puerperal psychosis only happens when you give birth and is different from other psychosis. It's still seen by others as though you've been mad (Glover, et al., 2014, p.263).

Some participants framed this view in terms of the requirement for specialist help, rather than stigma towards other illnesses:

[…] You're classed as a mental patient, rather than someone with an illness following childbirth. I think there's a difference you need specialist help (Robertson & Lyons, 2003, p. 419).

It was clear that participants felt strongly about the need for specialist, experienced staff treating them in a specialist unit.

Contact with professionals. One paper (2) referred to experiences of medical support while the remaining studies referenced support needs largely focussed on interactions and perceived attitudes from staff. Some participants spoke of negative experiences with an emphasis on lack of control or awareness of treatment decisions or justification:

[…] I was saying “no, no, no, no, no, no!” […] They wanted to give me an injection, I don’t know what kind of injection it was. (Day, 2002, p. 77).

Avoiding separation from the infant whilst receiving inpatient treatment was emphasised, and largely influenced recovery trajectory:

[…] You can’t logically figure out where your babies are […] The mother’s state of being is usually dependent on that baby. (Doucet et al., 2012, p. 239).

Most women described feeling unprepared and unaware of postpartum mental health issues, apart from one participant who valued this discussion:

[…] At antenatal classes there was definitely a realism that it could be the best and the worst of times […] so that was good (Hunter, 2013, p.50).

It was evident that it was important for women to feel prepared for the possibility of difficulties during motherhood. Negative experiences may have been exacerbated by the severity of symptoms, which increased confusion and distress.

Contact with non-professionals. Many women described the importance of practical support following discharge, utilising help from family members. This was connected to feeling untrustworthy in making decisions, and feeling overwhelmed:

[…] I couldn’t trust my own judgement […] I needed someone with me 24 hours, seven days a week (Doucet et al., 2012, p. 239).

The importance of contact with other women with postpartum psychosis was also prevalent. This served to validate, inspire, and normalise experiences:

[…] It was a relief to know…it does exist, other people have had it before me and there are things that can be done (McGrath et al., 2013, p.7).

Participants' experiences of non-professional support were variable, and possibly dependent on supporting individuals' experience and attitudes towards postpartum psychosis. Interpersonal relationships could either positively or negatively affect the individual's experience of postpartum psychosis:

[…] It's interesting how the illness ... feeds off the relationships you've got and some of your delusions and things can be directly related to other relationships you've got
with different people. But also it's your relationships with your family and your spouse that will eventually help you get better. (Wyatt, Murray, Davies, & Jomeen, 2015, p.435).

Additionally, relationships could be affected positively or negatively, including improvements in trust and respect, but could also include emotional and physical barriers which were challenging to overcome:

[…] All I wanted to do was hug her ... she was in this space that you couldn't get in ... I couldn't even touch you, you just pushed me away. (Wyatt et al., 2015, p.431).

Importance of information. Many participants talked about importance of information both before childbirth and at the time of postpartum psychosis. It was suggested that information may have assisted during recovery for both the individual and loved ones:

[…] Having what is going on explained to you earlier so that you can maybe help explain it to others is important (Doucet et al., 2012, p.239).

However, it was also highlighted that information needed to be 'screened' so that women did not feel frightened or overwhelmed. Information and support for loved ones was also highlighted as critical, yet variable across accounts.

‘Information’ also described sharing feelings about the experience. One participant advocated shared discussion during recovery:

[…] If there was some system in place […] the whole family would be involved so they can understand you and you can understand them, it would definitely speed up recovery (Heron et al., 2012, p.160).

Conversely, one participant suggested that although information had not been easily accessible prior or during the episode, this would not have changed the outcome:

[…] I don’t think there is anything that can stop it if it’s going to happen (Glover et al., 2014, p. 63).

It seems that information was generally considered useful for both the patient and their loved ones, but that consideration needs to be given to how much information is delivered, by whom and when. While information may not prevent postpartum psychosis, it may aid recovery.

Process of recovery.

One second order theme (1) succinctly describes the overall experience of postpartum psychosis - ‘shades of dark with a ray of light.’ Although recovery was often deemed impossible or intangible at the beginning of the women’s journeys (reported by these women), recovery was indeed possible and experienced. All but two studies (5,7) described the participants’ process of recovery. Two aspects were consistent in the recovery process: the role of the infant and regaining and developing personal identity.

The role of the infant. The infant was considered pivotal in three studies (1,9,10), and participants described interactions with the infant as motivational in recovery and bonding:

[…] He was the key reason, he was the reason I wanted to get better (Plunkett et al., 2016, p. 4).

Increased confidence in caring for the child was viewed as a marker for recovery and improved mood:

[…] You just gradually start enjoying things more and more and noticing things more and more and feeling more confident in your ability to, erm, to look after the baby (Plunkett et al., 2016, p.6).

This particularly supported the notion by the mothers that they should not be completely or constantly separated from the infant during treatment.

Regaining and developing personal identity. The impact of postpartum psychosis on personal identity was devastating at first:

[…] Your whole being, how you see yourself, the kind of person you are, and your whole sense of identity is completely devastated (Heron et al., 2012, p.158).

Additionally, loved ones noticing changes in the woman's personality or behaviour was often the first indicator that something was wrong:

[…] It was about eight to ten days when my sister – and I think Robert as well – noticed that I was behaving not like myself (Wyatt et al., 2015, p.430).

However, a marker of recovery was the process of regaining and adapting to an adjusted personal identity, including a focus on positive characteristics which had developed as a result:

[…] You can sympathise, well empathise with people more because you've been there yourself. I think that has made me a better person (Robertson & Lyons, 2003, p.424).

This included an adjustment of priorities resulting from the experience, and many women described using their experience to support others, raise awareness, and challenge stigma:

[…] I would never have done this work before I was ill but now I feel I have something to offer them, and I want to give something back (Robertson & Lyons, 2003, p.424).

Line of argument synthesis

The line of argument synthesis summarises the synthesis of findings from individual research papers, to provide new understanding and interpretation (Noblit & Hare, 1988).

Themes of support needs and preferences, stigma and dismissal, acknowledging the terrifying and surreal world of psychosis, and process of recovery, are seemingly connected via the woman attempting to regain her identity, and appraisals of the experience of postpartum psychosis. It was clear that many women felt completely unprepared for the possibility of postpartum psychosis, and most participants stated that information provided by health professionals during pregnancy about potential postpartum illnesses, would have assisted. It was highlighted in one paper that it can be very difficult for personal relationships if the woman's delusions are grounded in the context of interpersonal relationships, which was reportedly a common occurrence (Wyatt et al., 2015).

There was a strong preference for postpartum psychosis to be viewed as a separate mental illness, with purely biological aetiology. Interestingly, many participants used stigmatising language to describe mentally unwell individuals without postpartum psychosis, whilst also describing a stigma towards postpartum psychosis.

‘Appraisal’ was also key in all aspects of postpartum psychosis and accounted for some differences between individual experiences (e.g., Kelly 1955/1991). For example, the role of appraisal was evident in relation to perceptions of failure as a mother and judgements about intrusive thoughts, which gave rise to distressing feelings of guilt and shame. To promote recovery and support women during this experience, a non-judgemental awareness is required by people surrounding women experiencing postpartum psychosis. Appropriate information should be provided, stigmatising attitudes and language avoided, and treatment individualised with attention given to the woman’s appraisal of her role as a mother and the experience of psychosis. Family interventions may

be appropriate to address the views of those supporting the individual and to aid their understanding of how to promote recovery.

Discussion

This review highlighted important factors for clinical practice and in deepening understanding of the experience of postpartum psychosis via synthesis of existing research. These findings support the work of researchers suggesting that the content of psychotic experiences often reflect social and personal contexts, e.g., wider societal pressures, unmet expectations of motherhood, and perceived lack of control (Rhodes & Jakes, 2000).

The meaning behind infanticidal and suicidal ideation have crucial implications for formulation and risk assessment. Additionally, the evidence highlights the importance of resisting a 'knee-jerk' reaction when women disclose thoughts of harming their infant, as distinctions were made between distressing, intrusive thoughts, and fantasy, and the intent associated with these. Panicked reactions are likely to result in reduced disclosure and honesty regarding these thoughts (Fairbrother & Woody, 2008).

Distress, particularly in the form of guilt and shame, were perpetuated by infanticidal ideation. This is an important consideration for services, as reduced disclosure may increase risk for both mother and infant and the level of disclosure was impacted by reactions from professionals (Dennis & Chung-Lee, 2006). Individuals felt more able to disclose when they felt safe, un-judged, and working with an experienced specialist in the field of postpartum psychosis.

It was deemed crucial by the women that they were not separated from their infant during treatment. However, managing proximity for women who resent or consider harming their baby, must be carefully considered alongside perceptual difficulties and distress which seemingly accompany postpartum psychosis and could make safe, effective child-rearing incredibly difficult during acute phases. The role of the infant was reported by the mothers as pivotal during recovery, and therefore general psychiatric units which resulted in separation were

deemed completely inappropriate by the mothers (1,9,10). Additionally, proximity assists with bonding during this critical period, and in prevention of later attachment difficulties (Plunkett et al., 2016). Access to mother and baby units and community treatment was variable across participants and locations, which is reflected in government plans to rectify this (Department of Health, 2016). However, the risk issues must also be considered by professionals, and ideally involving transparency and shared decision-making with the mother and/or family.

Personal shame and stigma from others were often associated with incongruence between expectations of motherhood and mental illness, particularly regarding 'failure as a mother' (4,6,9). It is important that discourses surrounding the potential reality of motherhood are openly discussed during the perinatal period. Results indicate that stigma perceived from society and family members was prevalent and affected recovery, which supports existing research regarding precipitating factors leading to postpartum psychosis, including pressure from the social context (Rhodes & Jakes, 2000). Interestingly, some participants also used stigmatising language to describe mentally unwell individuals without psychosis, perhaps indicating cognitive dissonance in reducing guilt or shame, and/or evidencing how these narratives are perpetuated. Subsequently, explicit communication from professionals describing the continuum theory of psychosis (Mannion & Slade, 2014) may be beneficial in tackling both guilt and shame and reducing stigma or judgement regarding mental health difficulties generally. It was highlighted that the way loved ones reacted to noticing a change in the woman had a big impact on the woman's experience of postpartum psychosis, so this may suggest that adequate information for loved ones is equally important and consideration should be given to this being provided antenatally before distress escalates (Wyatt et al., 2015).

Differences were noted between perceived and actual stigmatising experiences, which were perhaps due to the individual's learning history and experiences of the world thus far (e.g., Ellis, 1957). Tangible stigmatising reactions from others

may be explained by the stereotypes and lack of current knowledge surrounding mental illness, which is perpetuated by reluctance to openly discuss this (Pescosolido et al., 2008). Fear of stigma or other negative consequences also led women to purposely mask their distress and experiences (Wyatt et al., 2015).

There appeared to be a discourse surrounding professionals holding all power, whilst the women felt out of control and powerless over their own lives and bodies. This emphasised the need for appropriate information, rationale, and shared decision making (Ramon et al., 2017) throughout treatment. Further anxiety arising from ineffective support (professionals and non-professionals) is likely to contribute to further distressing symptomology, which supports the stress-vulnerability model (Zubin & Spring, 1977). Additionally, only one paper (2) described the importance of medical support, which may reflect changing priorities towards refinement of psychological treatment guidelines, which currently do not exist.

Conclusion

Crucially, consideration of personal appraisals, including the woman attempting to regain her identity, may assist with the recovery process and experience of postpartum psychosis. The importance of appraisal was evident throughout the review, particularly considering the continuum theory of psychosis (Mannion & Slade, 2014). It is essential that treatment, and support from non-professionals, are embedded within a non-judgemental, informed stance, so that stigma is not perpetuated. Within service provision, appropriate information must be readily available to both the woman and her family, whilst treatment preferences are discussed wherever possible. As a wider societal issue, discourses surrounding postpartum psychosis and mental illness require adjustment so that women feel more able to talk openly about their experiences and seek help as soon as possible. One way of informing and influencing wider society's views of postpartum psychosis is through conducting and disseminating research to aid understanding and challenge preconceptions. This starts from conducting further research in the field of postpartum psychosis, to aid deeper

understanding and challenge preconceptions. The quality appraisal in this review leads to recommendations for researchers include careful consideration of the following: researcher reflexivity, bias and epistemological position; detailed information regarding ethical issues and procedure; recruitment strategy; and consideration of time elapsed between illness and recall. Comparisons between inpatient and community experiences and different cultures would further inform practice. The facilitation of qualitative research is, in combination with quantitative methods, vital for specific guideline development.

Limitations

Studies were geographically diverse, spanning continents, and included recruitment from a range of settings. Participants across papers were recruited at different time points, ranging from 1-32 years since the episode. Subsequently, synthesised experiences may not accurately represent specific contexts or reflections of different time points. Although heterogeneity (the range of demographics and settings) ensured inclusivity of differing experiences, generalisability of study findings may be limited. However, including a wide range of studies is considered vital in forming higher order interpretations within meta-ethnography (Britten et al., 2002).

Most studies did not adequately consider reflexivity, researcher bias during the research process, or epistemology. Therefore, formulation of third order constructs were dependent upon researcher reports, lacking clarity on how second order constructs were derived from data.

The review was limited to inclusion of qualitative studies as it was not felt that quantitative researcher papers would answer the research question and aims, where understanding the personal experience was focal. However, the importance of measurement of distress and relationships is noted, and future quantitative reviews would be encouraged in deepening understanding of this phenomenon. Additionally, first-person perspectives were considered integral to answering the research question and ensuring that women's perspectives were communicated. However, postpartum psychosis is not a solitary experience,

and has a profound impact upon family, friends and partners. This review[6] did not include these perspectives but acknowledges the validity of these experiences.

Despite potential limitations, this review offers new understanding and insight beyond individual research papers alone, including clinical and research recommendations.

Contributors

SW, VDH and AT conceived of the study. SW undertook literature searches. SW and AT conducted data analysis. VDH provided specialist guidance on CASP criteria and assisted in finding research papers. SW and AT approved the final manuscript as VDH left the research post prior to publication.

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Competing interests

All authors declare no conflict of interests.

[6] Considered against the CASP checklist for systematic reviews (Public Health Resource Unit, 2010), this paper resulted in a score of 19 (maximum 22), with all criteria being met to some degree. Please see Appendix C for further details.

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Journal Paper

Compassion-Focused Therapy for individuals with antenatal mental health difficulties: A Hermeneutic Single-Case Efficacy Design (HSCED) series

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Journal Abstract

Background: Perinatal mental health difficulties affect 10-20% of women in the United Kingdom. Guilt and shame are recognised as major contributors to mental health difficulties and are particularly prevalent in women experiencing antenatal mental disorders. Compassion-Focused Therapy (CFT) is an integrative therapeutic model which aims to reduce psychological distress by increasing compassion and reducing guilt and shame.

Methods: This study employed an adjudicated hermeneutic single-case efficacy design series (HSCED) to investigate the effectiveness of CFT for antenatal women with mental health difficulties. This intended to answer three questions: (i) is there evidence of substantial change following a six week CFT intervention? (ii) are changes attributable to therapy processes, common factors, or other non-therapeutic explanations? (iii) are therapeutic processes CFT-specific?

Three adult pregnant women with mental health difficulties were recruited from a National Health Service community perinatal service and engaged in six individual sessions of CFT. A range of quantitative and qualitative clinical data were collated ('rich case records'), which included outcome measures, CFT-specific measures, and a participant change interview. Rich case studies were critically analysed by three independent 'judges' who provided opinions regarding the three research questions.

Results: According to judges only one participant changed substantially. Judges generally believed change was more likely due to therapy than extra-therapeutic factors. The majority opinion was that any participant change was more likely due to generic therapy or common factors, rather than CFT-specific factors. Helpful generic therapeutic factors identified by judges included mindfulness practice, formulation, psychoeducation, and therapist attributes.

Discussion: It is inconclusive whether six sessions of individual CFT are effective in reducing distress for antenatal women. CFT-specific measures

(increasing compassion whilst reducing guilt and shame) did not consistently reflect subsequent changes in outcome measures (client distress), suggesting that CFT-specific processes were not predominantly responsible for any positive client change.

Trial registration: IRAS project ID: 235605, REC reference: 18/NW/0076, University of Lincoln School of Psychology Research Ethics Committee: PSY1718393

Keywords: Compassion-Focused Therapy, Perinatal, Mental Health, Therapy, Intervention, Psychological Distress, Hermeneutic Single Case Efficacy Design.

Abbreviations:

CBT: Cognitive Behavioural Therapy

CEAS: Compassionate Engagement and Action Scale

CFT: Compassion-Focused Therapy

CI: Change Interview

CORE-5: Clinical Outcomes in Routine Evaluation-Outcome Measure

HSCED: Hermeneutic Single-Case Efficacy Design Series

MHD: Mental Health Difficulties

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

OAS: Other As Shamer scale

PQ: Personal Questionnaire

PTSD: Post-Traumatic Stress Disorder

SCP: Specialist Clinical Psychologist

UK: United Kingdom

WAI-O-S: Working Alliance Inventory – Observer – Short form

Declarations

Ethics approval and consent to participate: This study was granted ethical approval by the University of Lincoln School of Psychology Research Ethics Committee (PSY1718393), Greater Manchester Health Research Authority Panel, and Research Ethics Committee (18/NW/0076). IRAS Project number 235605.

Consent for publication: All participants consented to anonymised publication of data as part of this report.

Availability of data and material: The data that support the findings of this study are available from the University of Lincoln, Doctorate in Clinical Psychology data custodian but restrictions apply to the availability of these data, which were used under license for the current study, and so are not publicly available. Data are however available from the authors upon reasonable request and with permission of the University of Lincoln, Doctorate in Clinical Psychology data custodian.

Competing interests: The authors declare that they have no competing interests.

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Authors' contributions: SoW chose the project design, with guidance from DD and SaW. SoW applied for ethical approval with guidance from VDH and DD. SoW and KB identified potential participants and followed the recruitment process. SoW and VDH formed the participant demographic sheet and CFT therapy protocol.

SoW delivered the CFT intervention and collected all data, supervised weekly by KB and fortnightly by DD. SoW arranged practicalities such as GP room bookings, with advice from KB and VDH.
SoW and VDH selected appropriate psychometric measures.
AR conducted change interviews with participants.
CH and members of the Open House group reviewed the CFT protocol.
SoW scored the questionnaires. NGM provided recommendations regarding scoring of the PQ and CORE-5. DD assessed CFT intervention fidelity and working alliance.
DD assisted in reviewing rich case records and considering aspects of affirmative and sceptic cases, which were developed by SoW. SoW formed the write-up and data analysis. MG, TS and NGM reviewed case summaries and provided judicial reports whilst acting as independent psychotherapy 'judges' as part of data analysis.

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Dr Mark Gresswell, Dr Thomas Schröder, and Dr Nima Golijani- Moghaddam reviewed case summaries and provided judicial reports whilst acting as independent psychotherapy 'judges' as part of data analysis. Dr Nima Golijani-Moghaddam also provided recommendations regarding scoring of the PQ and CORE-5. Professor Michael Barkham also provided guidance on scoring the CORE-5.

Background

Perinatal mental health difficulties[7] (MHD) affect 10-20% of women in the United Kingdom (UK) during pregnancy, potentially continuing into the weeks or months following childbirth (Bauer, Parsonage, Knapp, Iemmi, & Adelaja, 2014). Worryingly, in the UK suicide is the leading cause of maternal death in the first year following birth (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK; MBRRACE-UK, 2017).

Early detection and treatment of perinatal MHD are therefore critical to ensure the welfare of the woman and infant (Howard et al., 2014), and can begin during the antenatal period (pregnancy). Untreated antenatal disorders are linked to multiple negative outcomes for the mother, including: reduced response to the infant's needs (World Health Organisation, 2007); impaired personal and social functioning (NICE, 2014); stress on the family system (NICE, 2014) and; the child potentially taken from parental custody (Howard, 2005). Potential future impacts upon the infant include: gastrointestinal difficulties (World Health Organisation, 2007); chronic and distressing mood disorders (Barker, Jaffee, Uher, & Maughan, 2011; Feldman et al., 2009; Leis, Heron, Stuart, & Mendelson, 2014; Reck, Müller, Tietz, & Möhler, 2013; Velders et al., 2011); negative internalising behaviour (Davis & Sandman, 2012); poor motor skills (Gerardin et al., 2011); reduced social competence (Korhonen, Luoma, Salmelin, & Tamminen, 2012) and; developmental risks in utero (O'Hara & Wisner, 2014); Research indicates that treating perinatal MHD at an early stage, i.e., during pregnancy, leads to improved developmental growth of the foetus in the womb alongside improvements in psychological and physical wellbeing for mother and child following birth (World Health Organisation, 2007).

Guilt and shame frequently occur in perinatal women, for example, manifesting as anxious cognitions due to concerns around motherhood 'performance' (Beck, Emery, & Greenberg, 1985), sudden sense of responsibility (Oluyori, 2014), and

[7] Definition: mental health disorders which occur during pregnancy, up to one year following delivery, or relating to mental health difficulties which were present pre-pregnancy but compounded during pregnancy (O'Hara & Wisner, 2014).

societal expectations of a ‘good mother’ (Sutherland, 2010). However, guilt and shame may be particularly prevalent in women experiencing clinical disorders (Beck & Barnes, 2006), which may be due to fear of social services involvement arising from MHD and feeling shamed by society for not adhering to expectations of motherhood (Maimon, 2012). Guilt and shame can worsen symptoms of MHD due to the individual feeling unable to disclose symptoms and seek support (Dennis & Chung-Lee, 2006), which increases the risk of chronic and more intense MHD (Dunford & Granger, 2017). Guilt and shame are now recognised as major contributors to a range of MHD (Gilbert, 2009; Gilligan, 2003) and can significantly predict subsequent postnatal disorders (Dunford & Granger, 2017).

A psychological model which specifically targets guilt and shame-related distress is Compassion-Focused Therapy (CFT). CFT is an integrated therapeutic model which draws upon social, developmental and evolutionary psychology, Buddhist practice, and neuroscience literature (Gilbert, 2009), with emphasis on affect regulation systems (Gilbert, 2005) and attachment principles (Bowlby, 1969). CFT attempts to reduce psychological distress by increasing compassionate action and engagement (Gilbert & Miles, 2000). Guilt and shame are targets of change in CFT as they are strongly related to difficulties with compassion and high levels of self-criticism (Gilbert, 2009). Therefore, a particular focus in CFT is strengthening compassion (“a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it”; Gilbert et al., 2017, p.1) and is a proposed mechanism of distress reduction due to a negative correlation between compassion and psychopathology (Leaviss & Uttley, 2015).

Research into CFT has demonstrated positive outcomes for a range of individuals experiencing MHD, including psychosis (Mayhew & Gilbert, 2008), social anxiety (Boersma, Håkanson, Salomonsson, & Johansson, 2015), self-harm (Judge, Cleghorn, McEwan, & Gilbert, 2012), eating disorders (Gale, Gilbert, Read, & Goss, 2014), trauma (Beaumont, Jenkins, & Galpin, 2012), bipolar affective disorder (Laithwaite et al., 2009), and traumatic brain injury

(Ashworth, Gracey, & Gilbert, 2011). However, there has been little focus on perinatal populations with MHD, and literature is particularly sparse regarding interventions for antenatal women specifically. Nonetheless, there is increasing evidence supporting CFT and positive outcomes (Barnard & Curry, 2011; Gilbert, 2010b; Gilbert & Procter, 2006; Hofmann, Grossman, & Hinton, 2011). Additionally, compassion-based interventions for perinatal women with MHD have thus far shown effectiveness in reducing psychological distress, for example, depression and anxiety (Cree, 2015; Kelman et al., 2016).

As CFT has a unique focus on attachment and emotion regulation which aims to stimulate the bonding Oxytocin system, it is particularly apt in reducing maternal distress and positively impacting the mother-infant relationship (Cree, 2015; Galbally, Lewis, Ijzendoorn, & Permezel, 2011). This reflects more recent recognition of the power of attachment and affiliation with self and others - emphasised by CFT (Kelman et al., 2016). This development has occurred in response to findings which suggest severe self-criticism and non-affiliation with others underpins depression and anxiety, which commonly occur within the perinatal population (NICE, 2014). The specific focus of CFT is salient as it extends beyond existing therapeutic models and targets attachment and affiliation to others – key components of the mother-infant relationship (McGrath, Peters, Wieck, & Wittkowski, 2013). Potential health benefits arising from the cultivation of affiliative relationships and strengthening self-soothing, may particularly benefit pregnant women (Kelman et al., 2016). Compassion cultivation targeting affiliation towards the self and others is a key process in CFT, and research suggests this has a positive impact on the immune system, frontal cortex, cardiovascular systems (Singer & Bolz, 2013), and prosocial and empathic behaviour (Weng et al., 2013).

Despite promising findings, the CFT evidence base is in its infancy compared to interventions such as Cognitive Behavioural Therapy (CBT), yet has been found to be more effective than CBT for perinatal women (Kelman et al., 2016). Existing NICE guidelines for psychological intervention during the perinatal period (NICE, 2014) recommend “psychological intervention (e.g., CBT)” yet

existing research appears focussed on the CBT model despite highlighted limitations in efficacy for pregnant women with MHD. Investigating psychological intervention effectiveness is particularly pertinent for perinatal populations given acknowledgement that psychological intervention is an important alternative to psychiatric medication due to risks associated with medication during pregnancy (Weissman et al., 2000; Yonkers, Blackwell, Glover, & Forray, 2014). Although other therapeutic models have demonstrated effectiveness for perinatal populations, interventions such as CBT seek to reduce positive symptomology (Sensky et al., 2000), but do not routinely target residual feelings of distress, such as guilt and shame (NICE, 2014) which can impact on recovery and relapse (Smith et al., 2006). CBT for postnatal depression is less effective than CBT for depression in the general population (Perveen, Mahmood, Gosadi, Mehraj, & Sheikh, 2013), is often less effective than 'standard postnatal care' (Perveen et al., 2013), and rates of attrition in psychological interventions are higher in perinatal women than the general population, which may suggest that existing recommended treatments have poor acceptability for this population (Katz et al., 2008; Ugarriza, 2004). Additionally, qualitative data highlight that due to complexities and differences existing for perinatal women, CBT can be ineffective and produce conflicting messages about 'normal' experiences during the perinatal period (Knudson-Martin & Silverstein, 2009; Templeton, Velleman, Persuad, & Milner, 2003).

Existing research has also increasingly highlighted the pivotal role of common factors such as the therapeutic relationship in aiding client change (Wampold, 2015). This raises the question of whether these findings are replicable for an antenatal population, whether CFT-specific processes are responsible for any change which occurs as opposed to generic therapeutic aspects and techniques, and whether existing experimental methods have incorrectly assumed a causal relationship between outcomes and intervention rather than extra-therapeutic factors (Elliott, 2002). Subsequently, understanding processes of change is important in specifying intervention guidelines to enable clinicians to prioritise techniques and therapeutic focus. This is particularly pertinent given the time-limited nature of pregnancy and early intervention, and potential

service limitations regarding number of sessions which emphasise the need for effective therapeutic intervention.

The lack of CFT research appears unusual given published theoretical links between attachment, hormones, and bonding between mother and infant, which are targeted in CFT interventions. Broader research in this area has been hindered by methodology which has employed single participant experimental designs which failed to investigate the 'how and why' of change whilst assuming the intervention itself was responsible for change, and lack of investigation into CFT-targeted processes. Therefore, there is a lack of articulation about specific aspects of therapy which result in psychological improvement. Methodologies which examine processes of change in detail are therefore imperative, given the infancy of CFT in demonstrating theory-practice links, and vague guidelines regarding psychological interventions for antenatal MHD specifically. To explore the efficacy of CFT for women with antenatal MHD and increase understanding of the potential change mechanisms in CFT, single-case research is a pragmatic first step (Holman & Koerner, 2014). The HSCED method seeks to investigate what works and why in psychological therapy (Benelli, De Carlo, Biffi, & McLeod, 2015). A case series approach provides opportunity for replication and implication of results, and subsequently increases theoretical generalisation and practical implementation (Iwakabe & Gazzola, 2009). The HSCED method enables a more precise understanding of the active component responsible for client change and can be used to understand whether CFT contains specific factors which distinguish this model from other approaches (Leaviss & Uttley, 2015).

Research question and aims

This study employed an adjudicated HSCED (Elliott, 2002; Elliott et al., 2009) to investigate the effectiveness of CFT for antenatal women with MHD, with specific examination of multi-level change processes. In accordance with aims of the HSCED method, this study aimed to answer three key research questions:

1. Is there evidence of substantial change following a six week CFT intervention?
2. If so, are changes attributable to therapy processes, common factors (e.g., the therapeutic relationship) or other non-therapeutic explanations?
3. Are therapeutic processes CFT-specific?

Method

Participants and setting

This research adopted a pragmatic constructivism viewpoint aligning the philosophical underpinnings of the HSCED method (pragmatism) whilst considering the epistemological view of single-case design. Pragmatism supports use of a mixed methods approach whereby qualitative and quantitative methods can be used in a compatible way, rather than forced choice between methods (Tashakkori. Teddlie, & Teddlie, 1998).

HSCED prioritises depth and focus on few participants. Three participants were recruited as per recommendations regarding replicability (McLeod, 2013) from an NHS community specialist perinatal team. The inclusion criteria were: (a) referred into the perinatal service and pregnant (deemed to be experiencing clinical distress as accepted by service), (b) over 18 years of age, (c) capacity to give informed consent (d) spoke English fluent enough to enable completion of outcome measures, engage in an interview, and engage in therapy, (e) reported high levels of guilt and shame, and (f) not engaging in other structured psychotherapy.
The exclusion criteria were: (a) no longer able to give consent due to lack of capacity, (b) intellectual disabilities restricting adherence to CFT protocol, (c) symptom severity preventing engagement in the intervention, (d) deemed a risk to others, and (e) due to give birth during the intervention.

Recruitment process

Following institutional (NHS and Lincoln University) ethical approval, potential participants who met the inclusion criteria were initially approached by a clinician within the service. Upon expressing interest in participating, potential participants were assessed by the specialist clinical psychologist (SCP) regarding inclusion/exclusion criteria and appropriateness for a CFT intervention, and then gave consent to be contacted directly by the primary researcher. Four individuals indicated interest in participating, three of whom were included in this study and one individual who was due to give birth over the course of the intervention and therefore excluded from participating. The inclusion/exclusion criteria were kept as broad as possible to reflect 'real world' clients accessing community perinatal services.

Design

In order to investigate the research aims, the HSCED method utilises a comprehensive range of qualitative and quantitative data collection sources, which are analysed to form a 'rich case record'. As part of this rich case record, an affirmative and sceptic case for each client were constructed from examination of data. The judicial process was added in an attempt to protect against researcher bias in analysis and presentation of both affirmative and sceptic cases (Elliott et al., 2009). This study subsequently recruited 'expert judges' to determine client change and attribute likely influential factors (Elliott et al., 2009).

Judges. Three clinical psychologists were recruited to the study. All judges were independent to the research[8] and had differing theoretical orientations alongside clinical and research expertise.

Measures

A combination of self-report psychometric measures, observer measure, client change interview (CI), and session notes, were utilised to investigate the

[8] Independent in terms of not acting as research supervisors

research questions. These measures aimed to track weekly changes, CFT-specific processes, pre/post therapy outcomes, and explore reasons for change. Outcome data indicated whether significant client change had occurred. It was also hypothesised that if CFT-specific processes were responsible for change, then increases in CFT attributes would simultaneously occur with improvements in distress. To investigate whether therapy was responsible for change, process-outcome tracking assessed whether improvements in distress correlated with sessions which the client described as helpful in the CI, or alternatively whether improvements appeared due to life events described by the client.

Quantitative measures aimed to assess *how much* the client changed and were chosen to best meet research aims whilst considering the benefit-burden ratio for participants. Measures were given at the beginning and end of therapy, and some administered every session. 'End of therapy' measures were obtained at the end of session five in an effort to avoid collecting measures coinciding with a predictable 'dip' in scores relating to the final session before therapy ends (Owen, Drinane, Adelson, & Kopta, 2017). Descriptive overviews of psychometric measures are presented in Table 4 below.

Collection of qualitative data aimed to assess *how* the client changed (Elliott, 2002) and involved CIs with participants, alongside therapist process notes and reflective notes. CIs were prompted by the Helpful Aspects of Therapy form (Llewelyn, 1988) and guidance by Elliott, Slatick, and Urman (2001).

Change interview. A key component of the HSCED method involved a CI with the participant in order to identify potential reasons for any changes which occurred (Elliott, 2002). One to three weeks following completion of the intervention, each participant spoke with an external researcher (a trainee clinical psychologist) about their experiences. These interviews were audio recorded and transcribed in order to make process-outcome links and change attribution.

CFT intervention

As no structured weekly individual protocols were published, a CFT protocol was developed for this study. This was based upon an existing group programme delivered to perinatal women by the SCP, a nurse learning pack by Michelle Cree ('Compassionate Mind Training: Family Nurse Partnership Learning Pack, 2011) and a workshop booklet by Paul Gilbert ('An Introduction to the Theory and Practice of Compassion Focussed Therapy and Compassionate Mind Training for Shame Based Difficulties', 2010a).

Each participant attended an initial assessment session with the therapist whereby initial measures were completed followed by six weekly[9] sessions of individual CFT. Sessions ranged from 1-1.5 hours dependent upon participant need. The therapist aimed to encourage increases in compassion whilst decreasing guilt, shame, and self-criticism via CFT-specific techniques and conversational focus, regardless of the presenting difficulty. Post-intervention protocol fidelity checks were conducted by a research supervisor. As CFT draws on techniques from other therapeutic models, e.g., CBT, it can be difficult to distinguish from other therapies. Subsequently, the research team agreed that fidelity would be checked by assessing whether the therapist adhered to the protocol, after receiving confirmation the protocol contained necessary CFT components. Fidelity checks were completed by a research supervisor who checked a 10-minute section from a beginning, middle, and later session for each client. It was deemed appropriate to analyse a selection of sessions as per the aims of the protocol adherence checks. A combination of sessions from the beginning, middle, and towards the end of sessions were analysed in an attempt to provide a representative sample of therapist behaviour (Nezu, Nezu, & Jain, 2008).

Please see Table 5 for an outline of targeted processes each session and techniques used to target these.

[9] Weekly where possible – occasionally participant was unable to attend each week due to life events.

Table 4.

Description of measures

	Target	**Item scaling and directionality**	**Psychometric data**	**Frequency of Administration**
Outcome Measure Personal Questionnaire (Shapiro, 1961)	Client-generated individualised measure of distress	Self-rated. Likert scale from 1-7; total mean score ranges from 1-7; higher score indicates higher distress.	Internal consistency: α = .80 Strong correlations with standardised outcome measures (Elliott et al., 2012).	• Assessment (pre-therapy) • End of therapy • 1 and 3-month follow-up
Outcome Measure CORE-5 Outcome Measure (Barkham, Hardy,	Generic measure of psychological distress	Self-rated. Raw total score ranges from 0-20, raw mean score ranges from 0-4. For purposes of this research, total score = mean score multiplied by 10 to enable comparisons against other CORE measures. Adjusted	α = 0.81, SD = 9.33. CORE-10 norms utilised in calculation of the reliable change and clinical caseness:	• Assessment (pre-therapy) • Each session • End of therapy • 1 and 3-month follow-up

& Mellor-Clark, 2010)		total score ranges from 0-40. Higher scores indicate greater distress.	Internal reliability a=0.90	
Process Measure Other As Shamer Scale (Goss, Gilbert, & Allan, 1994)	CFT-specific processes: guilt, shame, self-criticism. A measure of global judgments about how the self is evaluated by others.	Self-rated. Likert five point scale (never, seldom, sometimes, frequently, almost always). Item scores range from 0-4 with total score ranging from 0-72, higher scores indicate greater external shame.	Internal consistency and validity high, deemed an appropriate evaluation tool (Vagos, da Silva, Brazao, Rijo, & Gilbert, 2016). All inter-item correlations statistically significant and positive at the 0.05 level (Goss, Gilbert, & Allan, 1994).	• Assessment (pre-therapy) • Each session • End of therapy • 1 and 3-month follow-up

Process Measure The Compassionate Engagement and Action Scale (Gilbert et al., 2017)	CFT-specific process: compassion	*Full measure*[a] Total score for each aspect of compassion ranges from 10-100. Scale ranges from 1 to 10 (1 = Never; 10= Always; Gilbert et al., 2017). Higher scores indicate greater compassionate engagement and action. *Action subscales* Likert scale from 1-10; each compassionate subscale total score ranges from 4-40. Higher scores indicate greater use of compassionate actions to deal with distress.	Mean total scores for UK females: CTO[b]: 72.51 (SD=15.67) CFO[c]: 55.70 (SD=15.47) CFS[d]: 58.19 (SD=15.05) (Gilbert et al., 2017). Correlations between all subscales for the CEAS were found to be significant and positive.[e]	• Assessment (pre-therapy) • Each session ('Action' subscales only) • End of therapy • 1 and 3-month follow-up

Other Working Alliance Inventory-Observer-Short form (WAI-O-S; Tichenor & Hill, 1989)	Therapeutic alliance	Completed by observer. 12 items taken from the original Working Alliance Inventory (Horvath & Greenberg, 1989). Scores ranging from 1 (never observed) to 7 (always observed) for each item. Total score ranges from 12-84. Higher score indicates greater working alliance.	Alpha coefficients =.93 .86, .87, and .82 for the total, bond, task and goal scores, respectively (Tracey & Kokotovic, 1989).	Each session (completed by an observer using audio recording of sessions).

[a] CEAS: Three sections pertaining to aspects of compassion; self-compassion, compassion to others; compassion from others

[b] 'Compassion to others' subscale

[c] 'Compassion from others' subscale

[d] 'Compassion for self' subscale

[e] For each specific focus of compassion (i.e. for others, from others, and to self), correlations between the engagement and action subscales were high (r=.67 to .83; Gilbert et al., 2017). Correlations between the different foci for compassion were moderate, with highest pertaining to the 'for self' compassion engagement scale, with 'for others' engagement scale, at .44 (Gilbert et al., 2017)

Table 5.

Description of sessions including targeted CFT attributes[10] and skills

Session	Key session points	Key techniques	CFT attributes targeted	CFT Skills
Preliminary assessment session with therapist	• Explain intervention and commitment required. • Discuss communications if either unable to attend. • Opportunity to answer any questions from participant. • Participant signs consent form. • Participant completes preliminary measures. • Speak to participant about why they are here, and what current difficulties they are experiencing.			

[10] Please see extended paper 1.5.1 and 1.5.2 for further information about compassionate attributes and skills.

	• Start thinking about provisional formulation (historical influences, key fears, safety behaviours, unintended consequences, self-to-self relating; please see Appendix K).			
1 ‘Understanding our emotions’	• Participant completes weekly measures. • Reflection on between-session tasks. • Collaborative construction of formulation. • Discuss ‘old brain’ and ‘new brain’ concepts. • Soothing body scan exercise. • Soothing breathing exercise.	Constructing/reviewing formulation, psychoeducation, zebra metaphor, soothing breathing, soothing body map. *Between-session task*	Empathy, non-judgement, sympathy, distress tolerance, care for wellbeing.	Feeling, attention, reasoning.

	• Describe the idea of our current state being one version of ourselves (convent vs biker gang metaphor).	Soothing exercise 2x week.		
2 ‘Motives and emotions’	• Participant completes weekly measures. • Reflection on between-session tasks. • The three affect regulation systems introduced (threat, drive, soothing systems) and how these might apply to client. • Client’s formulation linked to the three systems. • Exploration of how we feel, act, think, and behave like	Psychoeducation, linking drives back to formulation, drawing relative sizes of client’s own drives, compassionate memories, multimodal model of compassion, compassionate-self imagery. *Between-session task*	Non-judgement, sympathy, empathy, distress tolerance.	Feeling, imagery, behaviour, sensory, reasoning.

	when in each of these systems. • Draw the size of each of client's 'systems.' • Ask client what attributes and skills are needed to develop soothing content system – then introduce the idea of compassion. Can client remember a time where they were compassionate towards self and others, what attributes did they have? • 'Compassionate Self' exercise. • 'Compassion towards others' imagery exercise.	Soothing exercise 2x week

	• Start to think about why there may be psychological barriers to being self-compassionate.			
3 'Challenges to compassion'	• Participant completes weekly measures. • Reflection on between-session tasks. • Discussion about function of emotions. • How it feels to be in different emotional states and how they would relate to each other, including compassionate self and critical self. • 'Compassionate self' exercise.	Function of emotions, two teachers metaphor, two wolves metaphor, exploring fears about compassion, watching self through kind eyes exercise *Between-session task* Notice when in the different systems (drive, soothing, threat). Soothing task.	Non-judgement, sensitivity, care for wellbeing, empathy, distress tolerance	Reasoning, behaviour, feeling, imagery, [attention]

	• Explore barriers to compassion in more detail and where this might have come from. • Metaphor of the 'two teachers.' • Explore challenges in connecting with emotions. • Consider emotional conditioning in formulation. • 'Developing the compassionate image' exercise (imagined growing and being wise, strong, kind etc). • Focus on client's thoughts, emotions and physical sensations when being self-critical vs feeling	Practise 'developing the compassionate self.'

	compassionate towards someone. • 'Two wolves' story and how the intent to be compassionate is important – which wolf does client want to 'feed?' • Exercise imagining watching self this morning but from a compassionate point of view. • Exercise in extending compassion to others. • Rational vs emotional compassion and how to integrate these.			
4 'The different parts of you'	• Participant completes weekly measures.	Different selves and impacts, Christmas tree metaphor,	Sympathy, distress tolerance, care for wellbeing.	Reasoning, behaviour, feeling,

	• Reflection on between-session tasks. • Looked at the ‘spokes of compassion’ and how different selves affect what we focus on, think about, feel like, act like etc. • Practise what it feels like to show compassion to someone else. • Christmas tree metaphor. • Importance of practising compassion. • Imagery exercise on developing the compassionate-self further.	developing the compassionate-self further, memory of compassion. *Between-session task* Notice when in the different systems (drive, soothing, threat), soothing task, practise new task of ‘developing the compassionate-self further.’	imagery, sensory.

5 ‘Shame, compassion, and living in the mind of others’	• ‘Developing the compassionate self’ sheet and what this means to client. • Reflect compassionate concepts back to the formulation. • Consider compassion as a prescription for emotional wellbeing – e.g. if you don’t ask for help because this is seen as bad, what unintended consequences does that result in? • Use of imagery (thinking about food when hungry, someone we care about, someone who is critical) to demonstrate the power of imagery and critical voice vs compassion.	Looking at formulation compassionately, examples of compassionate people, unpleasant feelings, function of critical self, forming new habits, strengthening intent, compassion flowing out exercise, exploring shame *Between-session task* Notice when in the different systems (drive, soothing, threat).	Care for wellbeing, distress tolerance, non-judgement, sensitivity.	Reasoning, feeling, behaviour, imagery, sensory.

	• Discuss existing barriers to being self- compassionate, and existing functions of self-critic. • Talk about how the self-critic can be helpful sometimes, but that it perpetuates the formulation, and that client made a commitment to do things differently. • Discuss evidence that self-compassion and self-kindness are associate with wellbeing and being able to cope with life's stresses. • Imagery exercise on 'compassion flowing out,' particularly to people who it is more difficult to extend to.	Soothing task Complete 'developing the compassionate self' sheet. 'Compassion Flowing Out' exercise at least once over next week.	

	• Consider experience of assuming what other people think of us e.g. shame, and how connected to the three systems. • Client describes formulation in a compassionate way, and describes alternative. understanding and perspective. • Client completes end of therapy measures.			
6 ‘Planning for the future’	• Recap sessions and handouts. • Reflect on what has been more or less helpful for client. • Discussion about client’s short-term and long-term	Reviewing sessions, handouts, and techniques, planning for future, planning continuation of skills,	Care for wellbeing, sensitivity, sympathy.	Reasoning, behaviour, attention.

	goals in continuing to use the techniques and how they might stay well, particularly after the baby is born. • Consider whether CFT has helped client understand their problems better by looking at formulation. • Focus on how the intent is important in pursing compassion and mindfulness, and different ways of being mindful. • Summary sheet of compassionate attributes and skills, and how these relate to formulation.	short-term and long-term goals. *Further resources* 'Compassion diary' and further resources sheet. Continue helpful practice/areas client wants to strengthen. Pursue goals identified.	

HSCED Analysis

Stage 1: Rich case records. A comprehensive case record was formed for each participant. The components of analysis are described below (Elliott, 2002):

1. Describing therapist information and participant-specific contextual information, including any CFT protocol adaptations.
2. Analysing quantitative data comprising process and outcome measures.
3. Analysing qualitative data comprising the participant's CI transcript and organising this into Elliott's (2002) categories of change.[11]
4. Collating evidence for and against substantial change in participant distress over the course of therapy, using data from session recordings, therapist notes from sessions, CI, and psychometric measures.
5. Collating evidence for and against changes in CFT-specific processes i.e. increase in compassion and decrease in shame, using data from session recordings, therapist session notes, CI, and CFT-specific psychometric measures.

The affirmative case provided evidence to persuade judges that (a) the client substantially changed over the course of therapy, and (b) any change was primarily caused by receiving the CFT intervention, and sought to differentiate between CFT-specific factors and common factors. Conversely, the sceptic case draws on data and alternative explanations of outcomes to persuade the judges that (a) the client did not make substantial change or 'worsened', and (b) any positive change was largely attributable to factors outside of the CFT intervention, for example events occurring in the participant's life.

Stage 2: Adjudication. The judges were emailed the rich case records (including affirmative and sceptic cases) and CI transcripts. They were asked to complete a preliminary set of questions in order to determine whether they had particular allegiance with a therapeutic model and any clinical experience

[11] Change interview data were not analysed further (e.g., thematic analysis) to allow for transparency in presenting this information to the judges.

working with perinatal women or using the CFT model. The judges were then asked to complete Likert scales pertaining to how sure they were that the client had changed, and if so, how likely this was due to the CFT intervention. The judges were asked to comment on the most significant pieces of evidence which they had drawn upon to make these conclusions. Follow-up data were not available during the adjudication process. Please see Table 6 for information about the judges.

Table 6.

Judicial information

	Judge A	**Judge B**	**Judge C**
Preference for use of a CFT model/approach in clinical practice.	0%	25%	75%
Preferred therapeutic models/approach utilised in clinical practice	CBT and applied behavioural approaches.	CBT, Acceptance and Commitment Therapy (ACT), Behavioural Therapy.	Client-centred, humanistic, psychodynamic.
Clinical experience using CFT	No direct experience.	No direct experience.	Yes, with couples and shame-prone clients, especially in trauma work.

Clinical experience working with perinatal populations	None.	None.	1976-1977: Social worker on obstetric and maternity wards.

Results

The abridged results below collate participant and judicial data. The tables and summaries below were presented to the judges within participants' rich case records, and present data in accordance with each of the research aims.

Abridged results for 'Anna'[12]

Context and focal problems. Anna was an employed, married White British woman in her early 40s, 30-weeks pregnant with her first child. Anna reported previous diagnoses of anxiety and depression in her early 20s and also described incidences of bulimia and self-harm at that time.

Anna was referred into the perinatal service due to anxiety and depression which had worsened at the start of her pregnancy (triggered by work stress) but also because she was ambivalent regarding motherhood and reported "if I had the choice now, I would not go through with it." Anna was particularly anxious about being unable to connect emotionally with her baby. Anna was referred for the CFT intervention due to guilt and shame surrounding her ambivalence about the pregnancy, and self-critical comments.

Anna's anxiety and depression were not primarily targeted because the CFT intervention acted as an additional waiting list intervention to target guilt and shame specifically before she met with the SCP for an intervention to target her primary concern at that time. As Anna had already had a historical CBT intervention for anxiety and depression and reportedly found it unhelpful, the

[12] All participants given pseudonyms.

CFT intervention was expected to target the ’head heart lag’ described by Gilbert whereby distress cannot be rationalised using CBT techniques.

Quantitative results. Please see Table 7 for Anna’s measure scores.

Table 7.
Anna's measure scores

Measure	Pre therapy	S1	S2	S3	S4	S5	S6	End of therapy score	1 month follow-up[13]	3 month follow-up[14]
Outcome measures										
PQ	6	-	-	-	-	-	-	4 R+	5	5.5
CORE-5	22	18	20	18	12	14	16	14 R+	30 R-	16 R+
Process measures										
CEAS: 'for self' total	43	-	-	-	-	-	-	50 R+	56 R+	56
CEAS: 'for self': action	21	11 R-	16	25 R+	20	22	20	22	23	26
CEAS: 'to others' total	64	-	-	-	-	-	-	55 R-	65 R+	60

[13] Compared to end of therapy scores.
[14] Compared to one month follow-up scores.

CEAS: 'to others' action	32	20	22	29	22	26	24	26	29	29
CEAS: 'from others' total	45	-	-	-	-	-	-	46	61 R+	53 R-
CEAS: 'from others' action	25	17 R-	15	26 R+	23	20	19	20	26 R+	23
OAS	43	49	45	45	36	41	42	41	47	43
Working alliance										
WAI-O-S	-	5.33	6	6	6.5	7	7	-	-	-

Notes: S=session; 'End of therapy' score corresponds with S5 score. C denotes Clinically Significant Change compared to pre-intervention scores at p<.05; + or - indicates improvement or deterioration, respectively and R denotes Reliable Change. Weekly scores are compared to previous score. PQ: C = >3.25, R = 1.67, higher scores indicate higher distress; CORE-5: C = >11, R = 6, higher scores indicate higher distress; CEAS 'for self' total: C = <28.70, R = 5.81, lower scores indicate less compassion; CEAS 'for self' action: C = <3.08, **R** = 7.52 , lower scores indicate less compassionate action; CEAS 'to others' total: C = <41.80, R = 6.85, lower scores indicate less compassion; CEAS 'to others' action: C = <2.55, **R** = 5.80, lower scores indicate less compassionate action ; CEAS 'from others' total: C = <25.38, R = 3.99, lower scores indicate less compassion; CEAS 'from others' action: C = 5.19, **R** = 4.73, lower scores indicate less compassionate action; OAS: C = >28.38, R = 9.51, higher scores indicate higher shame; WAI: higher scores indicate greater working alliance.

Abridged affirmative and sceptic beliefs. The *affirmative case* stipulates that Anna changed substantially during the period of therapy and infers this change was caused by participation in the CFT intervention. This case drew on the following key pieces of evidence: statistically significant changes on Anna's PQ total score, CORE-5 score, and CEAS 'compassion for self' subscale.

Anna stated that the formulation was particularly helpful for her, which started in session one and was discussed further in session two. Therefore, it would be expected that Anna's scores may have improved at the beginning of session three. Anna's 'compassionate action for self' score and 'compassionate action from others' action score statistically improved at session three. Baseline scores could not be obtained, but in the assessment session Anna described her difficulties as having occurred for over 20 years, with little improvement, even from CBT. It can therefore be assumed that the therapeutic intervention is responsible for change with regards to chronic, pervasive difficulties. Anna also described experiencing a change in her ability to ask for help and be kinder to herself. Anna's PQ total score, CORE-5 score, and 'compassion for self' subscale score changed significantly pre-post therapy according to the reliable change index. The degree of change in Anna's compassion score is particularly notable when considering that Anna appeared to resist the notion of compassion throughout the majority of therapy and that this is a targeted CFT process.

The *sceptic case* rejects the case that Anna changed substantially during the period of therapy and infers that change was caused by extra-therapeutic factors. Anna's pre-therapy scores alone are not sufficient to establish whether the distress she experienced would have naturally improved as Anna neared her due date. On the measures where Anna was initially considered to be within clinical range, she remained within the clinical range at end of therapy. Anna's 'compassion to others' score statistically worsened pre-post therapy. Although

Anna reported finding the formulation process and teacher analogy[15] helpful, this was not represented in all subsequent scores, and any improvements were not stabilised. Additionally, formulation sessions corresponded to increases in the therapeutic relationship. Therefore, it may have been the increase in working alliance which resulted in the attribution that this technique was helpful. Conversely, a strengthening therapeutic relationship may have enabled the formulation process to be particularly effective for Anna. This is also true when considering that Anna found the 'two teachers' metaphor particularly helpful, yet this coincided with steady improvement in the therapeutic relationship. Finally, Anna was unsure whether she had changed as a result of the therapy or if it would have occurred regardless, "it's incredibly hard to know whether it's because of doing the CFT or just my situation."

Follow-up data

Anna completed measures at one- and three-month follow-up. At one month, her scores on one measure (CORE-5) had significantly worsened from end of therapy, whilst scores on four CEAS scales significantly improved. However, at three-month follow-up positive changes were not sustained. Her 'compassion from others' total significantly worsened, yet her CORE-5 distress score significantly improved. Anna stated in her CI that she wanted to try implementing techniques following therapy, and at one month following therapy it appears she was successful in increasing compassion, yet unfortunately these changes were not sustained at three months post-therapy.

Adjudication results

Table 8 summarises the judge's views on Anna's case record, considering the affirmative and sceptic cases, and any other evidence they considered significant.

[15] This technique asks the client to imagine two teachers at school; one strict and uncaring and the other compassionate yet authoritative. The client is asked which teacher they would want to be taught by and would benefit most from.

Table 8.

Anna's judicial results

	Judge A	**Judge B**	**Judge C**
Client change			
Extent of client change	Slightly – 20%	Slightly – 20%	Slightly – 20%
Certainty of decision	80%	60%	80%
Evidence presented in the rich case record which reportedly mattered most in reaching this conclusion	-Limited change psychometrics. -Anna was very vague about any change. -Anna commented that therapy has not changed thought processes. -Anna commented that therapy was not the right thing at the right time.	-Quantitative outcome and process data, post-therapy evaluation item, and CI. -Statistically reliable change on PQ and CORE-5. -PQ question- therapy helped 'little' -Anna described therapy as a 'pre-intervention.'	-CI. -Possible change from pre-contemplation to contemplation (useful step). -Unsure whether change actually occurred or just future potential? - Any statistically reliable change is not clinically significant.

Extra-therapeutic factors vs taking part in intervention			
Extent change was due to extra-therapeutic factors	Slightly – 20%	Moderately – 40%	Moderately – 40%
Certainty of decision	80%	60%	80%
Evidence presented which reportedly mattered most in reaching this conclusion	-Anna indicated that her situation was changing (pregnancy, process of pregnancy, etc).	-CI and notes. -Situational and developmental shifts (e.g., progression of pregnancy giving 'permission' to prioritise self/accept help from others) and extra-therapy events (holiday) as contributory. -Anna's attributes as potential setting conditions for change.	-CI supporting client factors: doubts about the therapy, lack of commitment to sustained practice, but some of the lack of change also attributed to external factors.

General therapeutic factors			
Extent this change, or lack of change, was due to other therapeutic factors. (e.g., common factors, generic therapeutic techniques, therapist factors)	Moderately – 40%	Moderately – 40%	Slightly – 20%
Certainty of decision	80%	60%	60%
Evidence presented in the rich case record which reportedly mattered most in	-Anna reported she did not see clear link between CFT and mindfulness.	-CI, strong alliance observations (WAI-O), expectancy rating. -Anna had general receptiveness and high expectations of therapy.	-References to information overload – possible criticism of the person delivering the psychoeducation. -Qualitative information (CI) didn't support strong WAI scores.

reaching this conclusion	-Mentions life events and their impact. -Anna indicates a poor fit between CFT and her thinking and events.	-Accessing therapy may have been experienced as enabling and facilitative of self-determination.	
CFT-specific techniques			
To what extent is this change, or lack of change, due to CFT-specific processes?	Slightly due to CFT – 20%	Slightly due to CFT – 20%	Moderately due to CFT – 40%
Certainty of decision	80%	80%	80%
Evidence presented in the rich case record which reportedly mattered most in	-Anna spoke of overwhelming information. -Anna found mindfulness helpful but	-Process measures, CI, and process notes. -Psychoeducation and formulation partially useful but general	-Negative consequences of CFT described in CI. -One potentially positive factor “the kind of teacher analogy” (159) was devalued and then fully negated.

reaching this conclusion	did not make strong link to CFT. -Anna describing impact of pregnancy.	resistance/scepticism re: CFT approach. -Lack of emotional engagement with (or self-practice of) core techniques. -Any shift in openness to CFT processes related to mindfulness. -Lack of equivocal change in process measures suggested CFT-specific processes not responsible.	
Summaries of change attribution			
Extent of client change	20%	20%	20%
Due to therapy	80%	60%	60%
Due to CFT: generic therapy	20% : 40%	20% : 40%	40% : 20%

Note. Judges were asked to first rate answers on a scale from 0-100%, with accompanying categories pertaining to each 20% score, for each item.

All judges referred to overall lack of change on psychometric measures as key in their decisions, alongside client quotations on the CI where Anna voiced uncertainty regarding any change. All judges referred to life events occurring in Anna's life, for example, her stage of pregnancy enabling her to ask for help. Two judges cited the strong therapeutic relationship (WAI-O scores) as important evidence for generic therapeutic factors. One judge highlighted that Anna stated she had not noticed changes in her thought processes. Similarly, only three CFT-specific techniques were named as seemingly important in any changes Anna made: the teacher analogy (although highlighted that Anna later negated this statement); some parts of the psychoeducation, and; the formulation. One judge noted that any lack of change may have been due to resistance/scepticism from Anna regarding the CFT approach and a lack of emotional engagement with (or self-practice of) core CFT techniques.

Anna voiced in sessions that exhibiting self-compassion and accepting compassion from others was connected to a profound sense of sadness due to past experiences, which may have explained her reluctance to do this and fluctuations in distress. Similarly, Anna voiced that she experienced shame speaking about emotions and connecting to them, which she was able to do in sessions at times. Subsequently, this may explain why her guilt and shame scores also fluctuated. Anna also stated in sessions that she found the concepts within CFT "woolly" and "wishy washy" which may have restricted her ability to connect to the therapy and make meaningful changes.

Abridged results for 'Claire'

Context and focal problems. Claire was a White British woman in her early 30's and was 32-weeks pregnant at session one with her third child. Claire was referred into the perinatal service due to a diagnosis of depression but also reported anxiety throughout the sessions. Claire was referred for the CFT intervention due to frequent self-critical comments and guilt and shame arising from attempts to put everybody else's needs before her own.

Claire's anxiety and depression were not primarily targeted because the CFT intervention acted as an additional waiting list intervention to target guilt and shame specifically before she met with the SCP for an intervention to target her primary concern at that time. Additionally, as Claire had experienced multiple manifestations of distress throughout adolescence and childhood, it was hypothesised that the CFT intervention would target underlying causes of distress rather than presenting symptoms alone.

Quantitative results. Table 9 presents Claire's measure scores. Claire did not return follow up data.

Table 9.
Claire's measure scores

Measure	Pre therapy	S1	S2	S3	S4	S5	S6	End of therapy score
Outcome measures								
PQ	6	-	-	-	-	-	-	5
CORE-5	36	26 R+	20 R+	28 R-	20 R+	30 R-	16 R+	30 R+
Process measures								
CEAS: 'for self' total	34	-	-	-	-	-	-	51 R+
CEAS: 'for self': action	7	12	14	11	9	8	26 R-	8 R-
CEAS: 'to others' total	84	-	-	-	-	-	-	80
CEAS: 'to others' action	36	36	36	36	36	32	36	32
CEAS: 'from others' total	30	-	-	-	-	-	-	46 R+
CEAS: 'from others' action	14	19 R+	25 R+	20 R-	18	16	36 R+	16 R-

OAS	44	43	40	47	41	46	36 $^{R+}$	46 $^{R-}$
Working alliance								
WAI-O-S	-	3.33	3.33	3.33	3.75	3.33	3.33	-

Notes: S=session; 'End of therapy' score corresponds with S5 score. ^{C} denotes Clinically Significant Change compared to pre-intervention scores at p<.05; + or - indicates improvement or deterioration, respectively and ^{R} denotes Reliable Change. Weekly scores are compared to previous score. PQ: ^{C} = >3.25, ^{R} = 1.67, higher scores indicate higher distress; CORE-5: ^{C} = >11, ^{R} = 6, higher scores indicate higher distress; CEAS 'for self' total: ^{C} = <28.70, ^{R} = 5.81, lower scores indicate less compassion; CEAS 'for self' action: ^{C} = <3.08, ^{R} = 7.52 , lower scores indicate less compassionate action; CEAS 'to others' total: ^{C} = <41.80, ^{R} = 6.85, lower scores indicate less compassion; CEAS 'to others' action: ^{C} = <2.55, ^{R} = 5.80, lower scores indicate less compassionate action ; CEAS 'from others' total: ^{C} = <25.38, ^{R} = 3.99, lower scores indicate less compassion; CEAS 'from others' action: ^{C} = 5.19, ^{R} = 4.73, lower scores indicate less compassionate action; OAS: ^{C} = >28.38, ^{R} = 9.51, higher scores indicate higher shame; WAI: higher scores indicate greater working alliance.

Abridged affirmative and sceptic beliefs. The *affirmative case* drew on the following key pieces of evidence: Three measures demonstrated statistically significant improvements from pre-therapy to end of therapy, although these did not appear clinically meaningful as Claire's clinical caseness status did not change during therapy. Claire also spoke positively of changes she had experienced throughout therapy in the CI. Claire attributed positive changes only to therapy and attributed any existing or fluctuating distress to external factors such as health appointments.

When the end of therapy measures were completed in session five, Claire said it was a "bad week" due to external events so measures did not represent improvements. This was reflected in her session six scores which largely improved from session five; three significantly improved. Baseline scores could not be obtained, but in the assessment session Claire described her difficulties as having occurred for over 15 years with no improvement. Claire reported in sessions that this was the first time she had experienced improvement in her mood and considered this to be a stable improvement as previous mood improvements had only lasted days.

The *sceptic case* drew on the following key pieces of evidence: Claire's scores on the PQ, OAS, and CORE-5 remained within clinical caseness from pre-therapy to end of therapy, despite any statistically significant changes. Three of Claire's scores significantly worsened at end of therapy: her 'compassion for self' action score, 'compassion from others' action score, and OAS score. Claire described feeling less anxious as her due date approached due to anticipating relief once the baby was safely born which may have accounted for distress reduction. Finally, any improvements in outcome measures did not correlate with process measures. Therefore, any changes do not seem connected to CFT-specific processes.

Adjudication results

Table 10 summarises the judges' views on Claire's case record, considering the affirmative and sceptic cases, and any other evidence they considered significant.

Table 10.

Claire's judicial results

	Judge A	**Judge B**	**Judge C**
Client change			
Extent of client change	Slightly – 20%	Slightly – 20%	Moderately – 40%
Certainty of decision	80%	60%	80%
Evidence presented in the rich case record which reportedly mattered most in reaching this conclusion	-Multiple positive change on several psychometrics although Claire remained in "caseness." -Claire struggles to apply some ideas when not in Sophie's calming presence. -Claire made some positive if slightly un-committed comments.	-The quantitative outcome and process data, post-therapy evaluation item, and client commentary. -Statistically reliable change in general distress remains in the clinical range. -No reliable change overall on PQ. -Some changes in other targeted process scores but	-Moderate self-reported change in the PQ - Claire may continue to improve on this measure. -The CORE-5 score remained within clinical caseness.

		these scores were already in a 'healthy' range. -Claire felt that the sessions were only 'moderately' helpful (below initial expectation). -Claire described minor changes, but in a qualified way -Some change may have been counteracted or masked by extra-therapy events (e.g., gestational diabetes.	
Extra-therapeutic factors vs taking part in intervention			
Extent change was due to extra-therapeutic factors	Considerably – 60%	Slightly – 20%	Not at all due to extra-therapeutic factors – 0%
Certainty of decision	40%	40%	60%

Evidence presented which reportedly mattered most in reaching this conclusion	-Claire mentions life events e.g., process of maternity, supportive friends and relationships.	-CI and notes. -Claire remained in 'severe' range of general distress (CORE-5) at post-therapy, despite significant improvement on measure. -Concomitant life events (e.g., gestational diabetes and associated stress/trajectory through care, care contacts, medication changes) may have buffered against change. -Situational changes may have been responsible for positive changes.	-No evidence for extraneous factors having contributed to any change –seems to be 'noise' rather than having a specific function.
General therapeutic factors			

Extent this change, or lack of change, was due to other therapeutic factors. (e.g., common factors, generic therapeutic techniques, therapist factors)	Considerably – 60%	Slightly – 20%	Considerably – 60%
Certainty of decision	80%	60%	80%
Evidence presented in the rich case record which reportedly mattered most in reaching this conclusion	-Claire doesn't really relate CFT-specific techniques/changes to her problems. -Claire cannot relate to CFT videos / the CFT approach without Sophie's calming presence.	-CI, alliance observations (WAI-O), expectancy rating. -Little mention of relationship (beyond noting therapist's 'calming manner') and observer-rated alliance is relatively low. -Some evidence of positive expectancy pre-therapy.	-Claire referenced the therapist being a "calming person" with a "nice calm voice." -The effect may have been in part CFT-specific (de-shaming) but no direct evidence for this. -'Practice' is another helpful common factor but little evidence that it is CFT-specific practice.

	-Mindfulness, anagram games, and body scans are not CFT-specific and likely just coping strategies. -Claire refers to Sophie's "Rogerian" approach as helpful. -Claire likely regressed to the mean through the course of her pregnancy as a result of exposure and events.	-Therapist's 'calm voice' was noted as a positive factor for engaging with specific techniques.	
CFT-specific techniques			
To what extent is this change, or lack of change, due to CFT-specific processes?	Slightly due to CFT- 20%	Considerably due to CFT - 60%	Moderately due to CFT – 40%
Certainty of decision	60%	60%	80%

Evidence presented in the rich case record which reportedly mattered most in reaching this conclusion	-Client refers to non-specifics such as the therapist's qualities and talks about non-CFT-specific techniques e.g., mindfulness, distraction. -Claire stated she struggles to apply compassion-based techniques in the real world.	-Process measures, CI, and process notes. -Evidence for increase in self-directed compassion and experience of compassion from others (CEAS scores and CI). -References to using techniques (e.g., mindfulness activities) and compassionate exercises. -Value of specific techniques appears more pronounced due to low working alliance. -However, little change in targeted processes of guilt/shame despite centrality of guilt to presenting concerns.	-Psychoeducation gave Claire a stimulus for reflection. -Claire described "going through all the compassionate image stuff" as helpful. -Mindfulness described as helpful.
Summaries of change attribution			

Extent of client change	20%	20%	40%
Due to therapy	40%	80%	100%
Due to CFT: generic therapy	20% : 60%	60 : 20%	40% : 60%

Note. Judges were asked to first rate answers on a scale from 0-100%, with accompanying categories pertaining to each 20% score, for each item.

All judges reported that positive changes on some measures contributed to their decisions, whilst acknowledging that Claire remained in clinical caseness from pre to end of therapy. Two judges referred to Claire's CI comments and stated that these were positive but at times vague. Using the CI and therapist notes, some judges used this evidence as support in the view that life events and supportive relationships may have been responsible for change, whilst another suggested life events were somewhat unrelated. Considering generic factors, Claire spoke positively about the therapist's "calming manner." Additionally, any techniques Claire mentioned as particularly helpful were not necessarily CFT-specific e.g., mindfulness. Judges commented on CFT psychoeducation as reportedly being helpful for Claire, and that Claire reported an increase in compassion during the CI. However, it was acknowledged by one judge that process measures did not reflect changes in outcome measures.

As Claire reported experiencing various MHD since adolescence, the short-term nature of the intervention may suggest that chronic MHD require a longer-term therapy. However, in the CI Claire reported numerous positive changes and stated she did not hope for any additional changes. Although the psychometric measures did not reflect the amount of change reported by Claire, this may indicate that the measures did not accurately capture Claire's experience. In addition, Claire voiced each session that she was confused by the wording of some of the question which may explain this discrepancy.

Abridged results for 'Ruby'

Context and focal problems. At the time of the intervention Ruby was a married White British female in her mid-30's. Ruby was pregnant with her second child and 31 weeks pregnant at session one. Ruby was referred into the perinatal service due to symptoms of post-traumatic stress disorder (PTSD) relating to the birth of her first child. Ruby had hoped that the CFT intervention would help her cope with the anxiety, guilt, and shame she was experiencing as a result of the PTSD symptoms, alongside ambivalence about the birth and

‘baby bump.’ She had not experienced MHD or significant trauma prior to the PTSD episode.

Ruby’s PTSD was not primarily targeted using a specific trauma-focused approach because Ruby refused a trauma intervention at the time of recruitment, stating that she did not feel able to discuss the traumatic events. Subsequently, the CFT intervention was offered as an intervention in itself to aid Ruby in caring for herself compassionately, with the possibility that this may also act as a ‘pre trauma’ intervention to help stabilise her feelings if she requested access to a trauma therapy at a later time.

Quantitative results. Table 11 presents Ruby’s measure scores. One month follow-up measures were not sent to Ruby due to her circumstances at that time.

Table 11.
Ruby's measure scores

Measure	Pre therapy	S1	S2	S3	S4	S5	S6	End of therapy score	3 month follow-up[16]
Outcome measures									
PQ	6.2	-	-	-	-	-	-	3.83 R+	1.8 R+ C+
CORE-5	24	20	24	26	24	12 R+	24 R+	12 R+	6 R+ C+
Process measures									
CEAS: 'for self' total	46	-	-	-	-	-	-	77 R+	70 R-
CEAS: 'for self': action	24	24	29	26	27	35 R+	31	35 R+	30
CEAS: 'to others' total	89	-	-	-	-	-	-	91	95
CEAS: 'to others' action	39	38	40	39	38	37	39	37	40
CEAS: 'from others' total	17	-	-	-	-	-	-	43 R+ C+	60 R+

[16] Compared to end of therapy scores.

CEAS: 'from others' action	8	8	9	18 $^{R+}$	9 $^{R-}$	12	10	12	26 $^{R+}$
OAS	31	33	20 $^{R+}$	18	22	14	22	14 $^{R+ C+}$	19
Working alliance									
WAI-O-S	-	4	4.5	5.25	4.83	6.08	6.75	-	-

Notes: S=session; 'End of therapy' score corresponds with S5 score. ^{C} denotes Clinically Significant Change compared to pre-intervention scores at p<.05; + or - indicates improvement or deterioration, respectively and ^{R} denotes Reliable Change. Weekly scores are compared to previous score. PQ: ^{C} = >3.25, ^{R} = 1.67, higher scores indicate higher distress; CORE-5: ^{C} = >11, ^{R} = 6, higher scores indicate higher distress; CEAS 'for self' total: ^{C} = <28.70, ^{R} = 5.81, lower scores indicate less compassion; CEAS 'for self' action: ^{C} = <3.08, ^{R} = 7.52 , lower scores indicate less compassionate action; CEAS 'to others' total: ^{C} = <41.80, ^{R} = 6.85, lower scores indicate less compassion; CEAS 'to others' action: ^{C} = <2.55, ^{R} = 5.80, lower scores indicate less compassionate action ; CEAS 'from others' total: ^{C} = <25.38, ^{R} = 3.99, lower scores indicate less compassion; CEAS 'from others' action: ^{C} = <5.19, ^{R} = 4.73, lower scores indicate less compassionate action; OAS: ^{C} = >28.38, ^{R} = 9.51, higher scores indicate higher shame; WAI: higher scores indicate greater working alliance.

Abridged affirmative and sceptic beliefs. The *affirmative case* drew on the following pieces of evidence: In the CI Ruby stated, “I just feel like I’ve got better.” She referenced multiple changes she had noticed from therapy and the positive impact of this. Ruby attributed any lack of change to her inability to practise techniques between-sessions as much as intended. Ruby’s scores statistically improved on six out of nine measures from pre-therapy to end of therapy and her ‘compassion from others’ and OAS scores moved her out of clinical caseness. In session five Ruby said she had managed to attend a midwifery appointment to discuss her birth plan, something she previously avoided due to being one of her strongest trauma triggers. However, Ruby reported that she managed to attend this appointment using the skills taught in sessions and felt “much better” and “positive” about the birth plan, which she acknowledged as a huge achievement. Ruby attributed worsening scores in session four to anxiety-provoking midwifery appointments. When asked whether Ruby felt the changes would have occurred on their own without therapy, Ruby was firm in her response stating that the changes would definitely not have happened if she had done these on her own.

The *sceptic case* drew on the following pieces of evidence. Although some of Ruby’s scores statistically improved, they did not all clinically improve. Ruby referenced a positive therapeutic relationship and found therapist attributes very helpful, so this may have influenced the way she appraised the helpfulness of the therapy, which is supported by the WAI scores. During the session where the affect regulation systems were explored (which Ruby reported as particularly helpful), there was a positive increase in the therapeutic relationship. This may explain why Ruby perceived this aspect as helpful, rather than the CFT-specific technique. Ruby also said that once the baby was born, she was very hopeful and optimistic that she would feel “back to normal again.” Therefore, the anticipation of the birth may have been responsible for the improvement in Ruby’s scores over time. Additionally, as Ruby had experienced PTSD from her first birth, the passage of time and gentle exposure to the trauma (as she occasionally chose to discuss this in sessions) may have been

responsible for the changes, as per research on exposure (e.g., Hembree, Rauch, & Foa, 2003).

Follow-up data

Ruby's follow-up data indicated that at three months post-therapy her distress continued to reduce, and compassion continued to increase. Ruby's CORE-5 and PQ scores statistically further improved and also took her from clinical caseness to below clinical caseness on both measures. One of the five PQ items – 'worry about the birth' - had occurred at the time of measure completion and relief may have accounted for part of the total score, although Ruby also completed four other items. Her CEAS 'compassion from others' total and action scores also improved statistically significantly, although her CEAS 'compassion for self' total score worsened statistically significantly. Ruby also reported that she believed therapy had helped her 'very considerably' which was an increase from her initial rating of 'considerably' at end of therapy, which suggests Ruby attributed the majority of change to therapy rather than life events.

Adjudication results

Table 12 summarises the judges' views on Ruby's case record, considering the affirmative and sceptic cases, and any other evidence they considered significant.

Table 12.

Ruby's judicial results

	Judge A	**Judge B**	**Judge C**
Client change			
Extent of client change	Moderately – Considerably – 50%	Considerably – 60%	Substantially – 80%
Certainty of decision	80%	80%	80%
Evidence presented in the rich case record which reportedly mattered most in reaching this conclusion	-Change on most measures. -Ruby self-reported positive change. -Ruby named specific techniques and examples of utilisation.	-Quantitative outcome and process data, post-therapy evaluation item, and client commentary. -Statistically reliable change (although remained in clinical range) on PQ and CORE-5. -Notable improvements in targeted processes of compassion and shame/guilt.	-CI - positive changes are not simply stated, but also differentially elaborated. -Positive self-report is repeated in the PQ. -In the therapist notes, Ruby talked about her PTSD symptoms during sessions, while having previously declared them 'off-limit' - a persuasive indication of lasting personal change.

		-Ruby reported sessions were 'considerably' helpful. -Ruby referred to multiple changes and was unequivocal about perceiving an improvement.	
Extra-therapeutic factors vs taking part in intervention			
Extent change was due to extra-therapeutic factors	Moderately – 40%	Slightly – 20%	Not at all due to extra-therapeutic factors – 0%
Certainty of decision	60%	60%	80%
Evidence presented which reportedly mattered most in reaching this conclusion	-Engaging more with other professionals e.g., midwife and consultant appeared beneficial. -Ruby described how external factors have impacted on her e.g.,	-CI and notes. -Ruby was unequivocal in stating that change would not have occurred without therapy. -Limited progress made around Ruby's primary problem area (worry about birth plan and baby),	-No obvious evidence for extraneous factors having contributed to changes.

	excitement about moving through pregnancy, friends, seeing CPN.	due to respecting her request of avoiding of. -Influence of some extra-therapy events (e.g., appointments with consultant and midwife).	
General therapeutic factors			
Extent this change, or lack of change, was due to other therapeutic factors	Considerably -60%	Moderately – 40%	Moderately -40%
Certainty of decision	80%	60%	80%
Evidence presented in the rich case record which reportedly mattered most in reaching this conclusion	-Ruby placed a lot of emphasis on her relationship with Sophie and events that have affected her moods. -Many of the techniques described (e.g. mindfulness,	-Alliance was observed to be strong (WAI-O ratings and CI) – suggesting that relational processes were favourable (for potentiating change).	-In CI Ruby referenced the therapist's personal qualities as important. -Common factor of feeling supported and empowered by

	relaxation, use of hand-outs, weekly sessions) are non-specific. -Specific things like self-compassion and shame were not really mentioned in the CI.	-Apparent sessional association between alliance ratings and outcome scores. -Evidence of general empowerment/developing self-efficacy over the course of therapy. -Expectancy effects may be a factor, but post-therapy evaluation exceeded pre-therapy expectations in this case.	tangible objects, rather than the CFT-specific content.
CFT-specific techniques			
To what extent is this change, or lack of change, due to CFT-specific processes?	Moderately due to CFT - 40%	Moderately due to CFT - 40%	Considerably due to CFT – 60%
Certainty of decision	80%	80%	80%

Evidence presented in the rich case record which reportedly mattered most in reaching this conclusion	-Ruby described some techniques that sound CFT-specific e.g., thinking about others in a compassionate way and three systems approach. -Other techniques sound very generic and not obviously CFT-specific e.g., mindfulness and relaxation.	-Process measures, CI, and process notes. -Reductions in guilt/shame (OAS) plus increases in compassion (CEAS). -Personal meaningfulness of reduction in OAS score was slightly undermined by the observed lack of (reliable) change in PQ item around 'feeling guilty'. -Clarity and specificity of Ruby's account of helpful CFT processes. -Difficult to attribute change to CFT-specific techniques independently of relational processes (high working alliance). -Some techniques that Ruby found helpful are common across various therapy models.	-More change appears to be attributable to CFT-specific factors than to common or extraneous factors e.g., references to specific techniques.

Summaries of change attribution			
Extent of client change	50%	60%	80%
Due to therapy	60%	80%	100%
Due to CFT: generic therapy	40% : 60%	40% : 40%	60% : 40%

Note. Judges were asked to first rate answers on a scale from 0-100%, with accompanying categories pertaining to each 20% score, for each item.

The judges drew on majority psychometric change and the CI whereby Ruby spoke strongly of positive changes made. One judge could not see evidence of extraneous factors having contributed, whereas another partially drew on factors such as engaging more with midwifery professionals. Another judge cited Ruby's comment in the CI that change would not have occurred without therapy. All three judges drew upon Ruby's comments in the CI which referenced CFT-specific content. One judge discussed contradictory process measure data and considered that the working alliance may have positively influenced outcomes.

Ruby may have engaged more effectively with the intervention due to a lack of previous mental health difficulties, which may have allowed her to connect with concepts such as self-compassion more easily. Additionally, Ruby was more easily able to draw upon and re-experience instances where she had demonstrated compassion towards others and experienced compassion from others, whilst Anna and Claire reported difficulty in emotionally connecting to these concepts. Ruby was optimistic that her mental health would improve once she gave birth and therefore this optimism may have contributed to her improved wellbeing. Lastly, as this was Ruby's first reported experience of MHD, this may indicate that a short-term CFT intervention is more effective for women experiencing singular, discrete episodes of mental distress, rather than chronic and enduring MHD.

Cross-case synthesis

Considering the three cases together and all judicial opinions, similarities and differences were identified across participant results:

Did meaningful change occur?

- Only one participant was rated by all three judges to have changed by at least 50% (ranging from 50-80%). Regarding the other two participants, the majority opinion was that the degree of change was only 20%.

- All three judges drew upon psychometric data in making this decision, alongside therapist notes and the CI. Participants had varying degrees of change across the psychometric measures; one participant had very little statistically significant or clinical change, another participant had some statistical change but little clinical change, and the third had both statistical and clinical change across measures.
- One participant demonstrated continued significant improved at three-months post-therapy.

Was therapy responsible for change?

- In eight out of nine opinions, the judges reported change was more likely due to therapy than extra-therapeutic factors (with the strength of ratings ranging from 60-100%). The judges particularly drew upon therapist notes and the CI in making this decision.
- Regarding salient non-therapy factors, the progression of pregnancy and mother's excitement or relief at the prospect of birth were considered important.

Were CFT-specific techniques responsible for change?

- Three out of nine judgements reflected the view that therapeutic change was more likely due to CFT-specific processes than generic therapeutic factors or common factors. Five judgements suggested that change was more likely due to generic or common factors, with one judgement suggesting it was equal attribution.
- A strong working alliance was commonly referenced, alongside specific therapist attributes which clients reported as helpful. The WAI-O scores and CI transcription were important pieces of evidence in this decision, alongside use of the graphs which for one participant demonstrated some positive change in weekly scores as the working alliance improved.

- Generic therapeutic factors (e.g., mindfulness) were described by the judges as linked to change. Participants described these as helped, and for one participant it was clear that distraction had been used to help her more successfully manage her distress.
- All participants referenced the formulation process as helpful in understanding their difficulties, referring to either the affect regulation formulation or the longitudinal formulation. One participant said that this process encouraged her to actively make changes.
- Any CFT-specific processes described by the participants and agreed as CFT-specific by the judges, included the psychoeducation component ('old brain/new brain' and the 'three systems' concepts). Furthermore, some of the judges highlighted that one client specifically described a more compassionate way of thinking in the CI.
- Crucially, the judges generally reported that changes in CFT-specific measures did not consistently reflect subsequent changes in outcome measures, suggesting that CFT-specific processes were not predominantly responsible for client changes.
- For two participants, difficulties connecting with or applying CFT techniques/skills outside the therapy room were apparent. One participant expressed a distaste for CFT in the CI, describing it as "woolly" and "wishy washy". The judges used this as evidence that CFT-specific processes were unlikely to have led to any of the changes.
- Taken together, the judicial panel reflected a mixed view: there was some evidence that change could be attributed to CFT-specific processes, with slightly greater emphasis placed on trans-therapy factors.

Discussion

Did meaningful change occur?

This appears to be the first paper which has evaluated effectiveness of a face-to-face, individual CFT intervention for pregnant women with MHD. From the adjudication process, it appears that CFT has varying effectiveness for women with antenatal MHD; for one participant this was an ineffective intervention, another reported positive change in all areas they had hoped for but these were not reflected in the psychometric measures, and the third participant reported quantitative and qualitative numerous positive changes as a result of this intervention. However, the judges' results collectively suggested an equal split between CFT-specific process and generic or common therapeutic factors in attributable to these changes. These results therefore only offer partial support for existing research which states CFT is efficacious for the antenatal population.

Was therapy responsible for change?

Pregnancy appeared to be both a hindrance and motivational factor across participants. One participant described pregnancy and upcoming motherhood as "giving permission" to engage with therapy and strengthen compassion, particularly given theoretical links to bonding and attachment. However, all participants also reported struggling to find time to practice the techniques as much as they had hoped to, due to a combination of preparing for the upcoming birth and being heavily pregnant. Attrition rates for pregnant women accessing psychotherapy is higher than in the general population (van Ravesteyn, Lambregtse-van den Berg, Hoogendijk, & Kamperman, 2017) so it is encouraging that all participants completed the intervention despite these challenges. Similarly, all participants reported increased engagement with social and/or professional support as they neared their due date, which may suggest extra-therapeutic factors as responsible for any change. Anxiety regarding the birth or pregnancy-related illnesses may also have led to regression towards the

mean as the birth date neared and subsequently led to reductions in distress when end of therapy measures were completed.

Were CFT-specific techniques responsible for change?

The therapist's "calming" voice and demeanour was named as an important attribute by two participants, alongside professionalism, personalism, being welcoming, organisation, predictability, non-judgemental, and smiling. One participant described how meaningful it was for the therapist to recall client anecdotes and the names of family members, as this felt very personal in a positive way. Subsequently, these comments support Wampold's (2015) theory of 'common factors' concerning relational and social processes within therapy (i.e. the therapeutic relationship and working alliance) which are pivotal in enabling client change, rather than model-specific techniques or processes. However, it becomes incredibly difficult to truly differentiate between CFT-specific processes and the working alliance, given that without a reasonable therapeutic relationship, the client is less likely to engage, attend all sessions, or participate in between-session practice (Laska & Wampold, 2014). In the CFT model, live demonstration and modelling of compassion and reduction of shame by the therapist is integral (Kolts, 2016). Therefore, based on the results and feedback from the participants, it was difficult to disentangle CFT from working alliance as participants and measures appeared to interconnect these aspects. As fluctuations in process measures did not correlate with fluctuations in outcome measures, it is difficult to therefore argue that any therapeutic change was due to CFT-specific techniques.

Limitations

The risk of researcher bias was likely increased due to the primary researcher also acting as the therapist delivering the CFT intervention. However, there were no particular orientations or conflicting interests from the primary researcher regarding whether CFT itself was responsible for change, although she washopeful that client distress would reduce due to some aspect given the additional role of trainee clinical psychologist. In order to minimise the

potential for bias, the primary researcher utilised supervision to ensure adherence to the CFT protocol whilst appropriately adapting this to meet individual need where required. Additionally, the conclusions of this research were based upon external adjudicators attributions in an attempt to further reduce bias as much as possible. The primary researcher therefore adopted a transparent and open approach in presenting all data and the full CI transcript. An advantage of this dual role was in enabling the primary researcher/therapist to provide additional contextual information and knowledge about the participants and therapist sessions during data analysis (McLeod, 2013).

Another limitation of the study was regarding the approximate calculations of the reliable change index and clinical caseness cut-offs for the CEAS and OAS. This was due to a lack of clinical norms for these measures, although these psychometrics were considered most appropriate for this study. However, an advantage of the single-case method, particularly the HSCED method, is that multiple sources of data are utilised during analysis and therefore judges also considered additional qualitative data and quantitative measures alongside other sources of information. This raises the question of why CFT-specific measures have not been developed further so that aspects such as reliable change, clinical caseness, and clinical norms, are established. This is a concern for CFT research as strong psychometric measures should demonstrate validity and accuracy in measuring key processes.

As the CORE-5 contains the least number of items, it has been presented as a concise instrumental measure for practitioners in assessing ongoing progress (Barkham, et al., 2010). Following consideration of participant load (particularly as participants were heavily pregnant) given that a number of measures were utilised at assessment, discharge, and each week, the CORE-5 was deemed the most appropriate measure for sessional use. However, the CORE-5 appears the least researched of all CORE-OM measures and subsequently psychometric data and norms were unavailable. This relied on adjustment of the raw scores in order to use the CORE-10 norms in calculating reliable change and clinical caseness.

The PQ has been used in many HSCED methods in assessing client change each session and pre/post therapy. In this study the PQ was used only as a pre and post-therapy outcome measure rather than weekly. The rationale for this was that it did not reflect the therapeutic model as CFT may not reduce 'problems' identified by clients but rather the way the person relates to themselves compassionately about the problem.

Consideration was given as to whether it was appropriate for the primary researcher (a trainee clinical psychologist) to act as therapist given the relative lack of experience in using the CFT model in comparison to the SCP. However, the HSCED method promotes utilisation of a naturalistic clinical setting (Dattilio, 2006), and the research team felt that this commonly reflects clinical practice whereby trainee psychologists, newly qualified psychologists, and clinical psychologists with little previous CFT experience may be delivering a CFT intervention (Leaviss & Uttley, 2015). This is particularly likely given that currently no accredited training is required to practice CFT. However, the nature of doctoral training is such that trainee clinical psychologists have a number of years' experience working in mental health settings, including working therapeutically, and are trained to think critically and flexibly across a number of models.

Clinical and theoretical implications

The findings of this study partially contradict existing research and literature which state CFT is an effective intervention for perinatal or antenatal populations. However, contradictions between this study and existing literature may be explained by components of the CFT intervention, the therapist delivering the intervention (although any issues were generally not reflected in WAI-O scores or CI data), stage of pregnancy, or previous lack of examination of CFT processes. These hypotheses will be explored below.

In consideration of the research aims, it is important to clarify whether CFT-specific techniques are truly limited to CFT or feature in other therapies. The psychoeducation component was referenced by both participants and judges as a CFT-specific process which contributed to change. Although psychoeducation

is an aspect commonly utilised in many psychological models (e.g., CBT), it is unclear whether participants would have equally benefited from information sharing which aided their understanding and narrative surrounding their difficulties, or whether the 'old brain new brain' information was particularly pertinent in reducing distress due to de-shaming.

Given that this intervention was six weeks in duration, findings may indicate that a short-term CFT intervention is more effective for clients experiencing an acute, distinct episode of MHD, rather than chronic and pervasive distress. Anna had previously experienced a CBT intervention and described the CFT intervention as "kinder" and "wasn't too difficult to incorporate." Although this may have protected against attrition and temporary increased distress, the "challenging practice" and direct cognitive challenging and behavioural exposure in CBT may lead to stronger outcomes. Subsequently, although CFT may have resulted in temporary calmness and relief due to lack of challenging practice, this may not bode well for long-term effectiveness. Anna's follow-up data indicate fluctuations regarding distress, compassion, and shame, which support this. The fluctuating scores may indicate the role of extra-therapeutic factors during this time, particularly considering that her child had been born just before the one month follow-up, although it was hoped that an effective intervention would protect against stressful life events. However, Anna's self-compassion endured beyond the intervention. It was hypothesised that this would be particularly difficult to maintain given expectations that a new mother might find it challenging to implement self-compassion and care. Therefore, this could indicate recognition that self-compassion remains important and requires prioritisation, and could be a key message embedded within future CFT interventions for this population.

Crucially, alongside specific de-shaming strategies, CFT can employ techniques from different psychological models, meaning it can be difficult to differentiate 'CFT-specific' techniques from generic techniques. All participants stated that the psychoeducation component was useful, and two participants described this as being very helpful in understanding their difficulties, with one participant stating they had accepted that their feelings were valid. Similarly, all participants

referenced the importance of formulation which is also supported by existing literature (e.g., Redhead, Johnstone, & Nightingale, 2015; Rogers, Reinecke, & Curry, 2005; Thew & Krohnert, 2015). Although the formulation process is used across therapeutic models, it is unclear whether a formulation process generally would have been beneficial, or whether it was the CFT formulation framework specifically which was helpful. Both participants referenced specific CFT aspects of the formulation, but this may have simply been repetition of the phrasing used rather than because these aspects were pertinent. Anna had previously accessed a CBT intervention where the formulation process would likely have been used. However, as she did not explicitly compare these two formulations within the change interview, the potential importance of the specific formulation model cannot be ascertained.

Furthermore, all participants referred to mindfulness as being particularly helpful, which supports empirical research claiming mindfulness is an effective intervention for anxiety, depression, and PTSD (Hofmann, Sawyer, Witt, & Oh, 2010). Although mindfulness is a key aspect of CFT, it is used within other models (e.g., mindfulness-based CBT; Segal, Williams, & Teasdale, 2002) and as an intervention itself. With regards to the antenatal population, current research suggest mindfulness during pregnancy and birth is effective in reducing symptoms of distress including the aforementioned difficulties (Duncan & Bardacke, 2010). Mindfulness interventions have also resulted in higher levels of compassion for participants (Dunn, Hanieh, Roberts, & Powrie, 2012), which may be due to both approaches targeting 'soothing systems.'

However, two participants named the 'two teachers' metaphor as helpful in understanding CFT concepts. Consideration could therefore be given to ensuring incorporation of this metaphor into standard CFT practice, although it cannot be certain whether this metaphor directly enabled client change or simply increased understanding of the concepts.

Existing research suggests that reducing guilt and shame occurs by increasing compassion and that this is pivotal in reducing distress and preventing long-term difficulties. However, the findings of this study suggest that distress can be

reduced regardless of compassion, and that increases in compassion do not necessarily correlate with reductions in shame. Conversely, as only one participant experienced both a significant reduction in shame and distress, this may demonstrate a link between de-shaming aspects of therapy and improvements in wellbeing. This therefore raises the question of whether reductions in guilt and shame have a fundamental role in reducing distress, or, whether increasing compassion accounts for these changes. Additionally, reductions in shame may have been due to the therapeutic relationship rather than CFT-specific techniques, although modelling compassion is key to delivering this intervention. Finally, the role of extra-therapeutic events cannot be ignored, and interactions with professionals or social acquaintances may alter throughout pregnancy, leading to changes in the way individuals perceive how others 'see' them.

Further research

All participants referenced difficulties in fully applying the intervention due to stage of pregnancy, this suggests that implementation of a CFT intervention earlier in pregnancy may improve outcomes. CFT interventions for women considering pregnancy may protect against reported pregnancy-related challenges which potentially interfere with intervention effectiveness (Kelman et al., 2016). However, it is also possible that CFT may not be an effective intervention for pregnant women with MHD, yet generalisability relies on experimental methods such as RCTs in order to assess majority effectiveness.

Given that participants reported that the CFT formulation was particularly helpful in aiding change and/or understanding, research comparing effectiveness of a range of formulations may highlight whether certain models or approaches provide more 'useful' formulations in aiding client change.

Lastly, although plentiful theoretical literature exists regarding CFT, empirical research investigating this as an intervention or processes of change is sparse. There may be a number of reasons for this: concerns by key authors and stakeholders that empirical research may not reflect theoretical developments, publication bias whereby any findings which do not support use of CFT are not

published, or recognition that evolutionary theory (which is key in CFT theory) and other components of CFT (e.g., the three systems) are not falsifiable unless combined with process exploration whereby measurement in one domain can be compared with another to investigate whether these processes have an influential relationship. Additionally, existing CFT-specific measures such as the OAS and CEAS require validation and further psychometric investigation to demonstrate whether these are truly fit for purpose in measuring CFT processes.

Conclusion

The novel contribution to the field of clinical psychology is that a six session face-to-face individual CFT intervention has inconclusive effectiveness for three women with antenatal MHD, due to lack of replicability across participants. This intervention appears more effective for women experiencing a single, discrete episode of MHD, for example, single event PTSD. Collaborative formulation, psychoeducation, attributes of the therapist, and mindfulness were named as particularly helpful aspects of therapy for all participants, which are not restricted to CFT. Subsequently, where the intervention appeared effective, it appears that generic therapeutic techniques were most pertinent in reducing client distress. Although the CFT model and live modelling of compassion may encourage a strong therapeutic relationship, this study does not provide strong evidence that change occurs via CFT-specific processes.

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Extended Paper

1.0 Extended Background

1.1 Perinatal disorders

Pregnancy, childbirth, and motherhood are commonly associated with high levels of anxiety and stress (Almond, 2005), even without clinical levels of mental illness accompanying this period. Women experiencing perinatal mental health difficulties (MHD) may be at high risk of long-term psychological and physical complications, which can impact upon both their own and the infant's wellbeing (Stein et al., 2014). MHD in the perinatal (during pregnancy and up to one year post-birth) population are often under-recognised. Subsequently, professionals coming into contact with pregnant women in the general population are increasingly advised to specifically ask about past and present MHD due to acknowledgement of the potential impacts of these (NICE, 2014). One of the reasons these difficulties may be under-recognised is that it can be difficult to differentiate between psychopathology and 'normal' changes which occur during pregnancy and after birth, illustrated by changes in appetite, sleep, and mood changes resulting from hormonal fluctuations. For example, differentiating between the normalising experience of 'baby blues' yet acknowledging postnatal depression (Robertson, Grace, Wallington, & Stewart, 2004).

Although MHD during this period do not differ significantly from MHD in the general population in terms of relapse rates and the course and nature of the difficulties, rates of relapse of bipolar disorder within perinatal women are higher in comparison to the general population (NICE, 2014). Similarly, women in the postnatal period are more likely to experience a first episode of bipolar disorder than at other stages of their life (NICE, 2014) and are at an increased risk of psychosis in comparison to non-perinatal women (NICE, 2014). The perinatal period carries additional risk and mental health complications due to both biological and psychosocial factors. For example, mothers may experience reluctance to seek support due to stigma associated with mental health problems during a traditionally 'joyful' time or may be fearful that social services will become involved (Dolman, Jones, & Howard, 2013). Pregnant women with MHD are also more likely to stop medication, which may be abrupt or without

guidance from healthcare professionals, and often exacerbates mental health conditions (NICE, 2014). Postnatal psychosis commonly has a more rapid and sudden onset than non-perinatal psychosis (Wisner & Wheeler, 1994), whilst women who have previously experienced bipolar disorder are at an increased risk of another episode in the early postnatal period (NICE, 2014). Prevalence of generalised anxiety disorder, adjustment disorder, and depression are also higher in the perinatal period than other times of life (Ban et al., 2012; Ross & McLean, 2006). It is also important to consider that the partners of women with perinatal mental health difficulties are similarly at an increased risk of mental health problems during this time (Lovestone & Kumar, 1993).

The predominant hypotheses regarding increase mental illness risk during the perinatal period regards pivotal hormonal changes (thyroid and pituitary hormones, cortisol and gonadal hormones), although no clear aetiological association exists (Henderson, Gray, & Brocklehurst, 2007). Postnatal psychosis and perinatal depression are associated with a particular sensitivity to reproductive hormone fluctuations (Bloch et al., 2000; Jones, Haug, Silverman, Stitzer, & Svikis, 2001). Additionally, the nature of birth complications or negative birthing experiences alongside potential foetal complications, provide opportunity for trauma and other mental health difficulties to develop in mothers (Turton, Evans, & Hughes, 2009).

1.1.2 Other common perinatal disorders. Panic disorder, generalised anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and tokophobia (phobia of childbirth), also noticeably occur during pregnancy and postnatally, and frequently occur co-morbidly with anxiety and/or depression (NICE, 2014).

1.1.3 Risk factors for perinatal disorders. Although MHD can affect any perinatal woman, risk factors include poverty, migration, extreme stress, exposure to violence (domestic, sexual, or gender-based), crisis or conflict situations, trauma, and low social support (World Health Organisation, 2007). Additionally, previous MHD, substance misuse, migration status, unplanned or

unwanted pregnancy, and family history of mental health, are also linked with perinatal MHD (NICE, 2014).

1.1.4 Treatment for antenatal disorders. Current National Institute of Clinical Excellence (NICE) guidelines state that women presenting with potential perinatal MHD must be assessed within two weeks of referral and offered psychological intervention within one month of initial assessment (NICE, 2014). Emphasis is also placed upon assessing and addressing the needs of family members, partners, and carers involved in the woman's life, alongside provision of culturally appropriate mental health information, specific concerns the woman may have about pregnancy or the foetus, and consideration of the impact of medication on breastfeeding and pregnancy (NICE, 2014). Guidelines also recommend consideration of whether the woman fears stigma by discussing MHD, fears judgement as a mother, or fears that the baby may be taken from the home (NICE, 2014). Interestingly, NICE-recommended treatment for tokophobia regards discussing the possibility of a Caesarean section, rather than focussing on the associated anxiety (e.g., exposure; Deacon & Abramowitz, 2004) or trauma-focussed work (Bhatia & Jhanjee, 2012). This may reflect a preference for practical solutions given the time-limited nature of pregnancy or that the phobia concerns a discrete, single event. For generalised anxiety, facilitated self-help treatments are recommended, with high-intensity therapy offered following lack of improvement after two weeks (NICE, 2014). Conversely, immediate high-intensity psychological interventions are recommended for social anxiety and PTSD (NICE, 2014). Recommendations for treatment of other MHD such as substance misuse, eating disorders, or bipolar disorder, follow general population NICE guidelines for these disorders, with additional scans or foetal checks where appropriate (for example, when the mother has anorexia nervosa or use of antipsychotic medication; NICE, 2014).

Current antenatal and postnatal MHD guidelines describe recommendations for perinatal depression, anxiety disorders, eating disorders, alcohol and drug misuse, 'severe mental illness,' and sleep problems (NICE, 2014). However, these are vague and focus on reducing the primary presenting symptomology

connected to the perinatal diagnosis. These guidelines do not currently specify interventions or provide guidance regarding secondary distress which may occur alongside antenatal MHD, for example, guilt, shame, and self-criticism regarding the experience. Secondary distress is likely to have a huge impact on recovery and the likelihood of future relapse (Smith et al., 2006), yet is absent from recommendations. Although other models such as CBT may target symptoms of depression and anxiety in the mother, this affiliative attachment relationship is not routinely targeted and therefore guilt and shame arising from this may lead to residual distressing symptoms for the mother (McGrath, Peters, Wieck, & Wittkowski, 2013) and impact further upon the mother-infant relationship (Fairbrother & Woody, 2008).

Crucially, psychopharmacological interventions for women carry risk of complications during pregnancy, such as long-term behavioural difficulties in the infant, biochemical addiction and subsequent withdrawal for the infant once born, and teratogenesis (Spinelli, 1997). Consequently, researching and specifying psychological interventions is imperative.

1.1.5 Consequences of untreated perinatal distress for mother and infant. Women in the perinatal period experiencing MHD are likely to experience additional difficulties alongside the distress and difficulties associated with the mental health problem itself (NICE, 2014). Tragically, the obvious impact is reflected in the relatively high number of women diagnosed with schizophrenia who have their children taken from their custody (Howard, 2005).

Regarding specific mental health difficulties and negative impacts upon the infant, these may include: increased likelihood of depression as a teenager (Stein et al., 2014); harmful cognitive internalisation and externalisation alongside emotional dysregulation resulting from maternal PTSD (Enlow et al., 2011); higher risk of sudden infant death syndrome arising from maternal perinatal depression (Howard, Kirkwood, & Latinovic, 2007) and; reduced birthweight and premature birth. These impacts are particularly likely in areas of

socioeconomic deprivation (Grote et al., 2010) or where the mother is self-harming or experiencing suicidal ideation (Lindahl, Pearson, & Colpe, 2005). For women experiencing perinatal schizophrenia or bipolar disorder, there is an increased risk of poorer obstetric outcomes including abnormalities in the placenta (abruption or previa), increased likelihood of premature birth, low-birthweight babies (Howard, 2005; Jablensky, Morgan, Zubrick, Bower, & Yellachich, 2005), higher rates of stillbirth (King-Hele et al., 2009), and neonatal death (Howard, 2005). Mothers with a history of anorexia nervosa are at increased risk of their infant having low birthweight (Solmi, Hatch, Hotopf, Treasure, & Micali, 2014), whilst mothers with a history of binge eating disorder are at increased risk of having foetuses which are large for their gestational age (Bulik et al., 2009). Foetal and infant outcomes are also worsened when the mother has experienced a drug or alcohol disorder (King-Hele et al., 2009). Additionally, mothers may be highly concerned that their mental health difficulties are having a negative impact on their infant, which can exacerbate existing distress (NICE, 2014).

1.1.6 Comorbidity of diagnoses. Within non-perinatal populations, anxiety and depression often comorbidly occur, for example, 50% of individuals experience both anxiety and depression (Kessler et al., 1996). Similarly, anxiety is often a prime symptom of PTSD (Craske et al., 2009). Within the perinatal population, 66% of women experiencing clinical depression postnatally also suffer from an anxiety disorder (Wisner et al., 2013). Additionally, 50% of women with 'treatment resistant' postnatal depression are also experiencing undiagnosed bipolar disorder (Sharma, Burt, & Ritchie, 2009).

1.2 Definition of psychological distress

Psychological distress can be defined as "negative mental health states" (Veit & Ware, 1983, p.730) or "a state of emotional suffering associated with stressors and demands that are difficult to cope with in daily life" (Arvidsdotter, Marklund, Kylén, Taft, & Ekman, 2016, p. 687), although it has also been acknowledged that it is difficult to explicitly and distinctly categorise positive and negative mental health states, and that there is likely to be bipolarity in people's

lives (Veit & Ware, 1983). However, for the participants who took part in this research intervention, they identified as experiencing significant psychological distress in their lives, which forms the referral into perinatal services.

1.3. Guilt and shame

1.3.1 Definitions of guilt and shame. Keltner and Buswell (1996, p. 155) described shame as "a moral transgression or after exposure of incompetence, whereby the person has "shown to be inadequate and feels worthless and inferior compared to others" (Ausebel, 1955, p. 378). Proposed theories of guilt and shame include a behaviourist perspective suggested by Izard (1978, p.450), who describes guilt as "a generalized or expectancy for self-mediated punishment for violating, anticipating the violation of, or failure to attain internalized standards of proper behaviour." Guilt and shame are distinct concepts but share traits, for example, both are considered 'moral emotions' and both involve internal attributions (Hoblitzelle, 1987). Therefore, research often refers to them in conjunction (e.g., McGrath, Peters, Wieck, & Wittkowski, 2013). Empirical studies have found strong correlations between guilt and shame (Ferguson & Crowley, 1997; Harder, 1995), and both are complex experiences comprising of cognitive, emotional and behavioural components (Oluyori, 2014).

1.3.2 Theories of guilt and shame. Proposed theories of guilt and shame include a behaviourist perspective whereby mothers with perinatal MHD may experience punishment which manifests as feelings of guilt and shame in relation to believing they have not adhered to societal expectations (Maimon, 2012).

Conversely, an evolutionary perspective (Trivers, 1985) suggests that guilt and shame are related to natural selection because these feelings prevent humans from carrying out actions that could harm interpersonal relationships and reduce subsequent protection. This fear of harming another directly and societal repercussions could be explicitly applied to women with perinatal disorders experiencing these emotions.

Cognitive theorists suggest that guilt and shame are consequences of anxiety (Beck, Emery & Greenberg, 1985; Gilbert, 2002), which would certainly echo findings within existing research for this population (McGrath, Peters, Wieck, & Wittkowski, 2013). For an individual experiencing feelings of guilt and shame, self-scrutiny is likely to result in self-blame which often heightens self-criticism (Oluyori, 2014). Therefore, shame and guilt at a cognitive level is characterised by critical thoughts surrounding one's own sense of self and responsibility (Oluyori, 2014). Gilbert (2002) stated that self-critical thoughts which devalue the self-concept are a crucial element of the internal component of shame. Furthermore, the role of secondary appraisals of shame and guilt can also hugely influence psychological distress, which often includes evaluations of blame and judgements about how the individual could have prevented harm or suffering (Lazarus, 1991). These appraisals have a critical influence upon how the individual views the future and subsequent coping potential (Lazarus, 1991). For a mother experiencing feelings of guilt and shame in the perinatal period and does not feel able to access support, there are likely to be long-term psychological impacts on the mother (McGrath, Peters, Wieck, & Wittkowski, 2013), the mother-infant relationship (Fairbrother & Woody, 2008), and in negatively affecting the recovery trajectory (Smith et al., 2006).

1.3.3 Consequences of guilt and shame. Regarding specific MHD, individuals with obsessive-compulsive disorder (OCD) often exhibit guilt relating to keeping other people safe which leads to ritualistic behaviour in an effort to prevent this harm coming to loved ones (Clark, 2012). People with depression may experience 'delusional guilt' as individuals may be tormented by thoughts that they are responsible for events such as catastrophic natural disasters, which manifests in severe depressive episodes (Clark, 2012). People with high levels of shame and self-criticism can find it very difficult to show kindness to themselves, experience self-warmth, or in displaying self-compassion, whilst high levels of shame and self-criticism often emerge from experiences of abuse, bullying, neglect, lack of affection, or high expressed familial emotion (Andrews, 1998; Kaufman, 1989; Schore, 1998). Individuals who have had these distressing early experiences often become highly sensitive to the threat of

rejection or criticism from others, and subsequently become self-attacking. This results in both the internal and external world being experienced as threatening and hostile, and subsequently when working with shame and self-criticism a therapeutic focus on the individual's memories of these early experiences is integral (Schore, 1998; Brewin, 2006; Gilbert, 2005). Individuals experiencing intense shame and self-criticism often find it incredibly challenging to generate feelings of safeness, warmth, and contentment, in their relationship with themselves and others (Gilbert, 2009).

Glover, Jomeen, Urquhart, and Martin (2014) suggested that early social and professional support positively impact on recovery for women with antenatal disorders, yet mothers experiencing guilt and shame are less likely to seek this. Other researchers have found that shame and guilt possess such strength that they result in emotional, cognitive, and behavioural responses such as silence, withdrawal, self-loathing and disgust at oneself (Tangney & Dearing, 2003). Understandably, these reactions have significant psychosocial repercussions for a person's wellbeing not directly but also due to decreased likelihood of help-seeking behaviours (Tangney & Dearing, 2003).

1.4 CFT

1.4.1 Theoretical basis. Compassion-Focused Therapy (CFT) utilises the definition of compassion originally found in Buddhist tradition, "as 'a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it" (The Dalai Lama, 1995). Paul Gilbert founded this therapy following observation of the difficulties many clients experienced in therapy due to feelings of shame and self-criticism (Gilbert, 2000). These difficulties became particularly evident during therapies such as Cognitive-Behavioural Therapy (CBT) where the client was able to generate alternative cognitions but reported that although they 'knew it' to be true, they still experienced distress due to feeling they still possessed unfavourable qualities or considered unfavourable people (Stott, 2007). Gilbert refers to this as the 'head-heart lag' in CFT and highlights that change cannot often occur on a purely cognitive level for these clients (Rector, Bagby, Segal, Joffe, & Levitt, 2000) and rather their inner voice

needs to be adapted, particularly when these inner voices exhibit hostility, anger, and disgust towards oneself (Irons & Lad, 2017).

Key underlying theories of CFT include evolutionary theory, particularly how we are motivated to seek social relationships (e.g., the formation of ranks and hierarchies, pursuit of intimate partners, yearning to live in groups, and caring for kin and group members) and the function of our emotional systems, particularly with regards to the fight-flight-freeze response, urge to seek resources, and feelings of safeness and contentment (Gilbert, 2014b). CFT draws upon neuroscientific research which evidences the link between affiliative motives and the impact upon self and emotional regulation (Cozolino, 2002), and biological research regarding the myelinated vagus nerve which is connected to parent-infant attachment and facilitates social affiliations, caring for others, and sharing resources (Depue & Morrone-Strupinsky, 2005). Subsequently, the focus of the psychoeducation component of CFT is in normalising feelings of distress as understandable responses which are largely out of our control, but initially acted as protective strategies in keeping us safe (Gilbert, 2010c). There is also emphasis on exploring the 'old brain' and 'new brain' which draws on evolutionary hypotheses regarding the way humans have evolved. The 'old brain' is a commonality amongst humans and all animals, and responsible for activating immediate emotional responses due to perceived threat. The 'new brain' is specific to human evolution and enables advanced cognitive abilities such as planning, organisation, and future predictions, yet also commonly results in rumination and worry (Gilbert, 2009). Understanding the 'two brains' explanation aims to reduce feelings of shame regarding understandable emotional experiences, whilst encouraging clients to 'step back' in order to understand their distress (Cree, 2011).

CFT describes three affect regulation systems, comprising the threat system, drive system, and soothing/affiliative system, which all interact with each other in an effort to keep us safe. CFT suggests that guilt, shame, and distress may arise from an over-stimulated threat system which is responsible for fight/flight responses but can be managed by strengthening the contentment and soothing

system, which is one of the main rationales for targeting this system via CFT (Gilbert, 2014b). More specifically, strengthening the contentment and compassionate system is accomplished by increasing client capacity to mindfully acknowledge, tolerate, explore, and direct affiliative affect and motives for themselves and others. In this way, compassion towards the self, others, and in accepting compassion from others, is cultivated and facilitates organisation of the 'new brain' to enable healthier mental wellbeing and prosocial behaviour (Gilbert, 2014a). The association between difficulties in exhibiting compassion and psychological distress is reportedly due to emotion dysregulation, difficulties with interpersonal relationships, and an inaccessible 'soothing system' in response to a sensitive threat system (Leaviss & Uttley, 2015). Subsequently, the biological response in compassion training encourages a reduction in the stress-linked immune response (Pace et al., 2009), as CFT describes the soothing system as responsible for feelings of safety due to absence of threat and linked to opiate hormones which mediate feelings of well-being and contentment (Gilbert, 2009).

Subsequently, a prime focus of CFT is in implementing psychoeducation and incorporating this into the formulation process so that clients are taught that distressing symptoms such as anxiety, depression, and anger are understandable and natural experiences. These experiences occur due to automatic responses in both the brain and body combined with previous experiences which have impacted upon the threat system and contentment system (Gilbert, 2009). In this way, emotional and behavioural responses are unintentional and consequences of these systems being uncontained and unbalanced (Gilbert, 2009). Compassionate practice serves to counteract the threat system by encouraging individuals to engage in compassionate and soothing actions, such as deliberately and mindfully slowing their breathing, imagining a compassionate place, and embodying a compassionate stance, alongside compassionately detecting and challenging the self-critical (Gilbert, 2009).

1.4.2 Self-compassion. An important distinction to make is between self-compassion and self-esteem. Self-esteem appears to increase when we are doing well or have achieved something, whereas self-compassion is present even in the face of perceived failure (Leary, Tate, Adams, & Batts Allen, 2007). 'Compassion' is defined in CFT as comprising of a number of attributes: sensitivity, sympathy, distress tolerance, empathy, non-judgement, and caring for well-being (Gilbert, 2009). 'Self-compassion' has been defined as understanding, acceptance, and forgiveness of oneself (Fanning & McKay, 2005). In comparison to self-esteem, self-compassion results in more positive well-being in a number of areas including aiding in academic disappointment or failure (Neely, Schallert, Mohammed, Roberts, & Chen, 2009; Neff, Hsieh, & Dejitterat, 2005), coping with stressful life events, and in reducing depression (writing oneself a compassionate letter appears most influential in the latter two aspects; Leary et al., 2007).

1.5 Compassionate attributes and skills

1.5.1 Attributes of compassion. CFT aims to decrease guilt and shame by strengthening compassion by targeting the following components (Gilbert, 2009):

- Care for wellbeing: Developing a motivation to be caring towards self and others – reduce suffering and flourish.
- Sensitivity: Developing sensitivity to our feelings and needs of self and others (different from vulnerability).
- Sympathy: Developing sympathy, moved and emotionally in tune with our feelings, distresses and needs for growth.
- Distress tolerance: Developing abilities to tolerate rather than avoid difficult feelings, memories or situations (including positive emotions).
- Empathy: Developing our insight and understanding of how our mind works, why we feel what we feel; how our thoughts are as they are – reflective functioning.

- Non-judgement: Developing an accepting, non-condemning, and non-submissive orientation to ourselves and others.

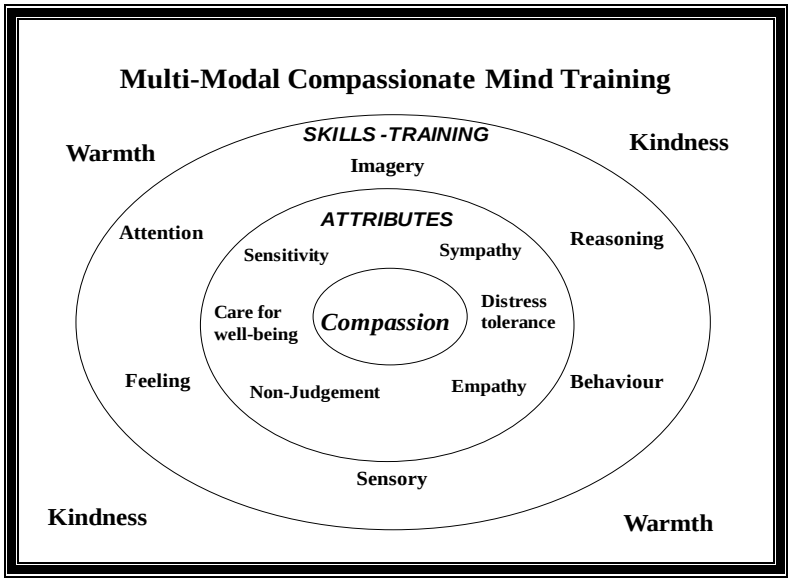

Figure 2. Multimodal compassionate mind training (Gilbert, 2010a)

1.5.2 CFT skills. CFT aims to strengthen the aforementioned attributes by implementing and strengthening the below examples of skills and techniques:

- Imagery (e.g., imaging compassion flowing in and out, imagining what it feels like to be compassionate towards others and have others be compassionate towards you, tuning into memories, imagining being self-compassionate).

- Reasoning (e.g., learning to think and reason, using the rational mind, looking at the evidence and bring a balanced perspective, writing down and reflecting on our styles of thinking and reasoning).

- Behavior (e.g., learning to plan and engage in behaviours that act to relieve distress, reducing safety behaviours in encouraging ourselves

and others to move forward in life goals, cultivating courage as compassionate behaviour often requires this).

- Sensory (e.g., considering compassionate visual image and accompanying senses).

- Feeling (e.g., learning to embrace and accept rather than push away difficult feelings and thoughts, curiously exploring this pain).

- Attention (e.g., learning to deliberately focus our attention on things that are helpful and bring a balanced perspective, developing mindful attention and using our attention to bring to mind helpful compassionate images and sense of self).

1.5.3 CFT Research. Existing CFT research has demonstrated effectiveness for a number of client groups and psychological difficulties, including self-critical depressed individuals (Gilbert & Irons, 2005), anxiety, stress, unhealthy submissive behaviour, self-criticism and shame (Judge, Cleghorn, McEwan, & Leary, 2012), distress due to chronic acne (Kelly, Zuroff, Foa, & Gilbert, 2010), psychosis (Braehler et al., 2013), personality disorder (Lucre & Corten, 2012), and complex mental health disorders (Judge et al., 2012). Alongside psychometric outcomes, self-report data supported CFT as an effective intervention, with individuals describing this therapy as easily understood, well-tolerated, helpful, and efficient in significantly improving mental distress (Judge et al., 2012). For individuals with psychosis, CFT was more effective in improving clinical improvement than 'treatment-as-usual' (TAU) and led to greater reductions in social marginalisation and depression for these individuals (Braehler et al., 2013). Comparable results have also emerged in studies involving individuals with personality disorder, with continued improvement at one-year follow-up (Lucre & Corten, 2012). For individuals with traumatic brain injury, CFT was found to be effective where previous CBT interventions had been unsuccessful (Ashworth, Gracey, & Gilbert, 2011). A meta-analysis supported this further by examining the relationship between psychopathology (stress, anxiety, and depression) and compassion, which

suggested a large effect size for this negative relationship (Macbeth & Gumley, 2012). Compassion has been found to be a strong moderating variable for depression and anxiety (Jain et al., 2007; Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Brown, & Biegel, 2007). CFT has also been found to be an effective therapeutic intervention in reducing self-criticism, anxiety, stress, depression, and shame in frequent day hospital attendees experiencing chronic difficulties (Gilbert & Procter, 2006), reducing distress in people with voice-hearing experiences (Mayhew & Gilbert, 2008), reducing depression, improving self-esteem, reducing negative social comparisons, reducing shame, and improving symptoms of mental health difficulties for individuals in high secure psychiatric hospitals including at six-week follow-up (Laithwaite et al., 2009). Considering neurobiological research, compassion-focused imagery has been shown to decrease heart rate and cortisol levels which supported the theory that compassionate techniques stimulate the soothing affiliative system, whilst reducing negative impacts from the hypothalamic-pituitary-adrenal axis activity in individuals high in self-criticism (Rockliff, Gilbert, McEwan, Lightman, & Glover, 2008).

2.0 Extended Methods

2.1 Rationale for HSCED method

Experimental methods, notably randomised controlled trials (RCTs), have been considered the 'gold standard' for investigating treatment efficacy due to excellent internal validity (Kingham & Gordon, 2004) yet a key flaw of RCTs are limited in their ability to generate causal inferences about whether the therapeutic intervention itself truly resulted in any change (Elliott, 2002). RCTs are limited in considering change attribution in individual cases, which reduces external validity which is valued in clinical practice (Rothwell, 2005). In their pursuit of high internal validity, RCTs miss the opportunity to gather pertinent data relating to common factors, extra-therapeutic factors, or specificity regarding the intervention, which are crucial in contributing to outcomes (McLeod, 1999). Subsequently, RCTs are ineffective in the pursuit of understanding regarding complex processes occurring with psychological therapy (Donaldson, Christie, & Mark, 2008). Researchers are increasingly appreciating the benefit in supplementing RCTs with more investigative and naturalistic approaches such as single-case design, to understand these outcomes and process (Bohart, Tallman, Byock, & Mackrill, 2011). Conversely, research methods employing single-case methods are integral to truly exploring key aspects which contribute to participant outcomes (Wampold, 2007). Single-case designs are advantageous in the systematic way they explore multiple different information sources in complex detail to ascertain a more accurate degree to which a participant has benefited from the therapeutic intervention (McLoed, 2010a). As the HSCED design has not been utilised in any studies investigating a CFT intervention for any client group, this study is clinically and methodologically innovative.

2.2 Development of HSCED method

Considering the above rationale for use of single-case design methodology, Elliott (2002) developed the HSCED method in response to a need to conduct research whilst enabling real world clinical applications. The 'hermeneutic' part of the single-case design refers to the systematic process by

which researchers use reasoning and investigative processes to test inferences and hypotheses, which enables judgements to be made about single events (Elliott, 2002). This interpretive process enables the researcher to organise data and comprehend complex and occasionally contradictory information (Elliott, 2002). A key part of the HSCED method is in ensuring a pragmatic, systematic, transparent, openness to the process to ensure data is adequately appraised in an effort to reduce bias (Elliott, Slatick, & Urman, 2001). The critical-reflective approach throughout is integral to the researcher's efforts in making good-faith attempts to provide similarly equivalent affirmative and sceptic accounts, even if this contradicts one's own interests (Elliott, Slatick, & Urman, 2001). The rationale for the addition of the adjudication process in the HSCED method is that it adds clarity and certainty in systematically considering the evidence (Stephen, Elliott, & Macleod, 2011). This process mimics the legal framework of considering evidence and making statements regarding attribution with certainty "beyond reasonable doubt" (Elliott et al., 2009). It was initially expected that the researcher would solely develop the integrative narratives compiling all available data in explaining the sequential processes by which the client changes. However, Elliott (2009) queried how effectively this could be done, and acknowledged the rich experience that external judges from varying theoretical orientations and experiences can contribute to the cases. Subsequently, the adjudication method was commonly adopted as part of the HSCED design.

The introduction of affirmative and sceptic cases alongside use of the adjudication process (Elliott et al., 2009) has enabled this process to become more stringent and to carefully examine all possible accounts with reduced bias by the researcher. Additionally, in acknowledgement that evidence of therapeutic efficacy is challenged when utilising few participant cases, Elliott (2002) and colleagues (Elliott et al., 2009) introduced guidance which recommended that three or more pieces of evidence were required in supporting a relationship between the therapeutic intervention and positive client change. These pieces of evidence may comprise: (1) retrospective attributions, (2) process-outcome mapping, (3) within therapy process-outcome

correlation, (4) changes in stable problems, or (5) event-shift sequences. Conversely, the sceptic case argues that any change which occurred was unsubstantial, trivial, or resulting from statistical errors, relational factors, measurement errors, or research variables.

Elliott's (2009) HSCED method comprises a systematic analysis of a rich data set, considering quantitative outcome measures, qualitative data from both the participant and therapist, data regarding any significant events occurring within and/or outside of therapy via a change interview (CI), and therapy-specific processes. This enables sensitive assessment of any client change and was influenced by Kazdin's (1981) research using single participant experimental design methodology. Kazdin (1981) specified that case studies must gather objective data, assess client functioning by using frequent weekly measures alongside pre and post-therapy measures, and to then repeat this process with other similar participants. Elliott was also influenced by Cook's (1979) publication exploring internal validity in quasi-experimental research designs which emphasised exploring competing explanations for participant change. Similarly, Bohart and Boyd (1997) stipulated that in order to provide a convincing causal relationship between therapy and client change, there must be additional evidence that change occurred and alternative explanations must be plausibly eliminated.

2.3 Philosophical underpinnings

The HSCED method adopts a pragmatic approach (pragmatism) to research methodology. As an interpretive stance is emphasised (rather than a traditionally experimental approach), this methodology systematically draws upon multiple rich datasets in an attempt to make sense of both qualitative and quantitative information, rather than relying upon abstract design features (Stephen & Elliott, 2011). Crucially, this method promotes a 'probabilistic' approach to knowledge claims rather than assuming 'absolute' answers to research questions (Elliott, 2015). In this way, pragmatism is an appropriate underpinning approach due to the importance given to suggesting probabilistic explanations of change, and emphasis on exploring and interpreting various data sources (Stephen, Elliot & MacLoed, 2011).

2.4 HSCED procedure

The HSCED method procedure comprises first collating rich case records, and then utilising the adjudication process to assist with analysis and exploring results. The rich case record process is based on Elliott's (2002) guidance and followed the below procedure:

1. Collation of contextual facts about the therapist and participant, including the participant's demographic information, presenting problem(s), history of mental health difficulties and any support/intervention resulting from these, personal circumstances, and perinatal-specific information. Additionally, information about the therapist is reported such as prior experience working with the therapeutic model.
2. Use of quantitative outcome measures to assess client-change prior, during, and end of therapy, including a measure which reflects the client's difficulties. Process measures are also used prior, during, and end of therapy to enable process-outcome mapping in an attempt to ascertain whether any changes are due to CFT-specific processes. Common factors such as expectations for therapy and the therapeutic relationship can also be measured this way to compare against any qualitative information gained from the client in the change interview. These can also be compared to weekly measures in an attempt to ascertain whether changes could be explained by common factors, whilst therapist notes and change interview questions prompt exploration of any extra-therapeutic factors which may have contributed.
3. A qualitative semi-structured interview following the intervention is a key part of the HSCED method; Elliott, Slatick and Urman (2001) introduced and utilised the Change Interview (CI) schedule. The CI provides opportunity to gain qualitative information about the client's experience of the therapeutic intervention, particularly regarding any helpful, hindering, and extra-therapeutic (e.g., life events) factors which were pertinent for them (Carvalho, Faustino, Nascimento, & Sales, 2008). The change

interview is ideally administered by a third party researcher in an effort to reduce bias, which was also implemented in this study.

The Helpful Aspects of Therapy (HAT) form (Llewelyn, 1988) is frequently used in HSCED research in order to provide prompts to investigate the impact of any 'significant events' which occurred in therapy, according to the client. This can be used formally in therapy sessions or used to structure conversation during the CI. In this research, the HAT form was implemented as a 'prompt' sheet during the CI whereby the interviewer was instructed to gather further information on any factors deemed important by the participant.

4. Records of therapy sessions e.g. audio recordings and therapist processes notes are used in order to pinpoint, corroborate and classify contradictions highlighted in the case record or CI. This can be particularly helpful when investigating client change and shifts in quantitative measures.

2.4.1 HSCED analysis. Within the analysis and formation of the affirmative and sceptic beliefs, eight possible explanations of change attribution are explored (Elliott, 2002). Please see Table 13 for these descriptions.

Table 13.

Elliott's (2002) explanations of change

Alternative explanations of change (Elliott, 2002)	**Description**
Non-significant improvements	Any apparent client changes are considered negative or trivial. Statistically significant and clinically significant changes on measures are helpful in assessment of this, alongside client and therapist reports.
Statistical artefacts	Apparent change may be due to measurement error, regression to mean, or experimental/research errors. Consideration of reliable change index calculations, replication of change across multiple psychometric measures, and consideration of past history and stability of client difficulties can be utilised in this assessment.
Relational artefacts	Change may be due to the client's attempts to please the therapist and/or due to the working alliance or positive rapport. Measures of therapeutic alliance and the therapist's knowledge of the client (e.g., whether they may answer in a purposely positive manner) can assist with this consideration.

Client expectations	The client's expectation of therapy may impact upon level of change made, which can be assessed via use of psychometric items (e.g., the PQ) and explored during the change interview.
Self-correction	This explanation suggests that self-help or temporary improvements in difficulties may be responsible for client change. Consideration of support, client attributes and behaviour, and history of difficulties, can help assess this factor.
Extra therapy factors e.g., life-events	This considers that any client change, although occurring during the period of therapy, may have been due to factors occurring outside of therapy. For example, life events for the client which had an impact on their wellbeing. The change interview and therapist notes can be helpful in assessing this explanation.
Psycho-biological Factors	Aspects such as medication and hormonal changes may be responsible for change, and can be considered via use of therapist notes, collection of client demographic information, and investigated during the change interview.
Reactive effects	Client change may be due to reactive effects arising from participating in the research study, e.g., participant bias and social desirability factors. The impact of taking part in research can be explored during the change interview.

2.4.2 Adjudication. Elliott (2009) advises that the judges should ideally be selected to represent a range of theoretical orientations. This was implemented within this research study and all judges possessed differing theoretical orientations and clinical experience, whilst all experienced in clinical psychology psychotherapy and research. After being approached by the primary researcher and agreeing to act as judges, the judges were given three weeks to complete their judicial summaries. They were provided with information about the study, additional information about their judicial role, participant case records, change interview transcriptions, and preliminary judicial questions regarding theoretical orientation and clinical experience. Please see Appendix D for these questions.

2.4.3 Analysis team. Aside from the primary researcher, the analysis team comprised two research supervisors (clinical psychologists) employed by the University of Lincoln as part of the Trent Doctoral Training in Clinical Psychology. In addition, the specialised clinical psychologist (SCP) working within the community perinatal team acted as a field supervisor, including provision of weekly supervision. The analysis team supervised the research project and provided guidance on recruitment, analysis, specific ethical considerations for the perinatal population, and the research process and study generally. As with the judges, all research supervisors possessed differing theoretical orientations and clinical experience, whilst all experienced in clinical psychology psychotherapy and research, in an effort to consider data and implications from multiple perspectives.

2.5 CFT intervention

Prior to the intervention starting, the CFT protocol was sent to an external clinical psychologist with particular interest and experience in implementing CFT, who made (minimal) recommended changes after checking she believed it adhered to the CFT model and contained all necessary aspects. This protocol was also sent to a registered community group comprising of women who had previously or were currently experiencing perinatal mental health difficulties, and had set up a specialist support network. Although the workbooks by Gilbert (2010a) and Cree (2011) were freely available online,

both authors were informed by an initial supervisor[17] (with whom they had an existing relationship) and agreed to these being used. The workshop booklet created by Gilbert (2010a) was provided for use by patients and/or professionals and guidelines suggest this can be used flexibly as required. The workbook created by Cree (2011) was initially created for family nurses and family nurse partnership supervisors working within the perinatal community. The lead researcher/therapist also attained membership of an online CFT community – The Compassionate Mind Foundation, run by Paul Gilbert. This provided frequent access to theoretical resources, membership discussions about theory and application, clinical resources, and research articles.

2.6 Participants and recruitment

Existing HSCED research studies have commonly utilised a single participant (Carvalho et al., 2008; Stephen, Elliot & MacLoed, 2011) due to the time-consuming, complex, and detailed nature of this methodology. However, case series research often utilises three participants in order to demonstrate repeatability of effects (McLeod, 2013). Although the theoretical standpoint of the HSCED method does not include achieving generalisability across populations, gaining a more precise understanding of what is working and why this is integral, is often improved via observation analysis of inter-participant comparisons (McLeod, 2013). Subsequently, three participants were recruited for this study. Recruitment was initially implemented from a single NHS site, but ethical and managerial approval was gained from two further sites should this have been required. The initial single site used for recruitment was chosen due to the permanent full-time presence of a SCP within this service who was also able to act as field supervisor for this research study.

All clients[18] identified as potentially suitable for the intervention chose to take part and all three of these participants completed the entire intervention. One client met the inclusion criteria but was due to give birth over the course of

[17] This supervisor initially acted as primary supervisor and field supervisor but left these posts a few months into the project.
[18] The terms 'client' and 'participant' are used interchangeably to reflect this dual-role

the intervention. Exclusion criteria did not include completion of psychometrics in order to ascertain clinical caseness, as clinical cut offs for most measures were approximately calculated for the purpose of analysis, as none of the measure authors stipulated cut off scores for clinical versus non-clinical populations. Subsequently, the research team agreed that to exclude participants based on these calculations may be inaccurate and unethical. Additionally, given that the targeted processes for this therapy were regarding high levels of guilt and shame as reported by the SCP, perinatal team, and client themselves, it also felt unethical to potentially state to the client that their self-critic or shame was not "severe enough" to warrant this intervention, once this had already been identified from multiple sources as problematic for the individual. Additionally, the CFT-specific psychometric measures created and used to measure guilt, shame, and compassion (by Paul Gilbert) do not stipulate clinical cut-offs in identifying clinical severity of difficulties. Similarly, as diagnosis or initial presenting clinical problem (aside from CFT-specific targets) were irrelevant in considering inclusion/exclusion criteria, it would not have been possible to use a common measure in identifying potential participants. As all participants were accessing the psychiatric perinatal community service, they had been diagnosed with a clinically significant MHD and were deemed to possess a clinical difficulty in order for their referral to be accepted and in continuing to receive support from the perinatal team.

After gaining appropriate ethical consent from the University of Lincoln and National Health Service Local Research Ethics Committee[19], alongside approval from the relevant NHS trust and service, the first author[20] compiled an information sheet to give to team members within the perinatal team and joined a team meeting to describe the research and provide opportunity for questions. Team members were then asked to identify potential participants who may benefit from CFT or any therapy from the specialised clinical psychologist (SCP) working for the perinatal team, including clients who were currently on the

[19] Please see extended paper section 2.10

[20] The first author was also the primary researcher and therapist for the CFT intervention

waiting list to see the SCP. The recruitment procedure (previously described) was then followed.

2.7 Therapist details

The therapist/researcher was a Doctorate in Clinical Psychology trainee in her second year of a three-year course, at the time of data collection. She was 29 years old at the time of the CFT intervention.

The therapist/researcher had previously delivered CFT-informed interventions during the doctoral training course, had attended face-to-face CFT training provided by Paul Gilbert (founder of CBT), and had completed an additional online course in CFT. There is not currently an official CFT qualification or accreditation, but supervisors experienced in CFT advised these steps would be very beneficial in providing the intervention. The researcher/therapist also received weekly supervision from the SCP within the perinatal team to discuss any clinical or protocol concerns and queries. The SCP was also proficient in using CFT and this model was commonly utilised within the service as part of a TAU group psychological intervention.

2.8. Therapist Observation

Process notes kept by the therapist provided important information about the client's expectation of therapy and any relevant background information. This information is summarised in the contextual client information described in the case summaries. Therapist process notes are also used to support evidence for and against client change and attribution.

2.9 Therapist and intervention integrity

Transparency was integral in communicating to clients and the perinatal team that a practitioner-research model was implemented, whereby the primary researcher also acted as the therapist (McLeod, 1999; Elliott, 2002). Fidelity checks completed by a supervisor identified that there were zero instances of notable digression from the protocol[21].

[21] As CFT incorporates aspects from multiple models, fidelity was assessed by checking adherence to the CFT protocol.

2.10 Epistemological position

Pragmatism developed in response to the dialectical positions of positivism and constructivism (Morgan, 2007), and emphasises the importance of pursuing the research question rather than striving to use a particular methodology (Frankel Pratt, 2016). The pragmatic researcher is able to maintain subjectivity in describing their own stance, experience, and bias, whilst aiming to be objective during data collection and analysis (Shannon-Baker, 2016).

Whilst the pragmatic position views causal relationships as existent and requiring careful interpretation, constructivism assumes that knowledge is constructed by individuals (Kuhn, 1970). The constructivism stance emphasises that there are many ways in which events can be interpreted by people, and that each of these perspectives are important but cannot be purely objective (Raskin, 2002). Epistemological constructivists believe that external reality is independent of the researcher, and it is therefore impossible for observers to understand and know any other reality except for the one they have constructed through their own understanding (Raskin, 2002). Subsequently, these constructions are invaluable in understanding the way events are perceived by people and in exploring human-made constructions. Information is considered as 'more or less viable' rather than judged on how 'accurate' it is (Raskin, 2002). It therefore makes sense that pragmatic constructivism is compatible with the HSCED method and accompanying stances, given that case study research considers causality and explanation whilst attempting to avoid a reductionist and dehumanising approach (Cook & Campbell, 1979).

2.11 Ethical considerations and procedures

The below ethical issues were given careful consideration prior and throughout the research study. Ethical approval was granted from the Health Research Authority- Greater Manchester (please see Appendix E) and Lincoln University School of Psychology Research Ethics Committee (SOPREC). The study was conducted in accordance with BPS ethical principles (2006).

2.11.1 Informed Consent. Upon assessment into the perinatal service, potential participants had the study introduced to them by the SCP, after preliminary 'screening' from the team when considering the inclusion/exclusion criteria. Once an individual indicated that they had a desire to take part in the study, they were given a Participant Information Sheet (please see Appendix F). The participant was asked for permission for the primary researcher to have their telephone number, and to be contacted by the researcher after 24 hours, whereby the details of the study were explained. To ensure that the participant had sufficient time to consider participation, they were then contacted again at least 24 hours later by the primary researcher to discuss their decision regarding participation. At this point, verbal consent was obtained by the primary researcher, at least 48 hours after the participant was given the information sheet. Written consent was obtained in the preliminary/'assessment' session with the primary researcher, following further details about sessions, the research study, and commitment required. The participant was reminded throughout this process that any healthcare or treatment would not be affected regardless of their decision regarding participation, including if they chose to prematurely terminate their participation in the study. It was emphasised to participants that the CFT intervention was in addition to TAU, and that all individuals could request to see the SCP following the intervention at the earliest opportunity if they so desired.

Written informed consent (please see Appendix G) was collected from each participant before they started the intervention and prior to collection of demographic information by the primary researcher. Please see Appendix H. Participants were informed when meeting with the SCP that the primary researcher would not have access to any medical files, and this was retained throughout the entire study. During the intervention phase, GDPR regulations were updated and implemented by Lincoln University, and participants were therefore provided additional information regarding these regulations and consent to continue was checked.

Participants were provided with a verbal and written debrief, which included signposting to a number of services, alongside a reminder that participants would remain under the care of the perinatal service following the intervention. Please see Appendix I.

2.11.2 Reducing participant burden. As the CFT intervention was an addition to TAU, all standard care and treatment was received by the participant, except for immediate access to clinical psychology. However, the participants who took part in this study were either on a waiting list to see the SCP or were not awaiting therapy at the time of participation, so access to the SCP was not delayed. Participants were informed prior to giving consent that they could not receive care from the SCP, or any other structured therapy outside of the perinatal service until completion of the CFT intervention had occurred, or they could otherwise choose to prematurely end the CFT intervention if they wished to request direct care from the SCP more urgently. However, they were made aware that the SCP may not be available immediately due to the waiting list. Participants continued to receive care from their community psychiatric nurse and/or psychiatrist as per usual prior to the CFT intervention.

Process and outcome measures, particularly those given weekly, were deemed to cause some burden to the participant. After discussion with the HRA ethics board, it was deemed appropriate to find a shorter weekly distress measure in order to reduce this burden, which is why the CORE-5 psychometric was utilised. The process measures were used in the group CFT programme within the perinatal service, but not used on a weekly basis during group or individual therapy. Participants were informed of the request to complete outcome and process measures and reminded of their right to withdraw at any time. Participants were informed that if they chose to prematurely end their part in the intervention or expressed an interest in accessing further support following the study intervention, they would be signposted back to their referring clinician in order to organise further TAU. No participants withdrew consent. One participant expressed an interest in accessing care from the SCP during the intervention, but stated she wanted to first complete the CFT intervention.

2.11.3 Safety considerations. If clients were receiving input from the psychiatrist or CPN, this was not categorised as an exclusion criterion due to service protocol whereby all patients accessing the service immediately accessed a specialist professional. Additionally, due to ethical considerations, it was not deemed appropriate to remove this specialist input once they chose to take part in the CFT intervention, particularly as the CFT intervention was deemed an addition to TAU (in line with NICE guidelines).

Participants would have been removed from the study due to any arising safety issues, including pregnancy complications which may have affected or been affected by the intervention, failure to adhere to intervention requirements, and withdrawal of consent. If the participant prematurely gave birth prior to the end of the intervention, they would have been offered the opportunity to continue the CFT intervention for ethical reasons, although another participant would have been recruited to enable a thorough analysis of three participants.

It was anticipated that participants could have become distressed throughout the intervention, but this was not expected to exceed risk associated with TAU. When this occurred within sessions this was managed using clinical skills and judgement from the primary researcher, as an experienced trainee clinical psychologist under close supervision by an experienced SCP. Participants and the primary researcher had access to all emergency contact numbers and signposting services, whilst the participant also remained under the care of the perinatal team who could offer support if required. Participants were informed verbally and via the Participant Information Sheet that any safety issues would be discussed with the perinatal team.

The nature of CFT or any form of psychological therapy is that the client can expect to discuss sensitive and difficult feelings and emotions. However, this was purposefully at the discretion of the client and not pressured by the therapist. Although any therapy can be destabilising for clients, the perinatal team and SCP carefully assessed the participant's ability to take part. However, as the CFT intervention aimed to attenuate distress and shame and reduce

psychological distress, it was expected and hoped that taking part in the intervention outweighed any potential risks, and participants were made aware of this via the Participant Information Sheet.

2.11.4 Further support. Participants were advised that they could request further TAU following the study intervention, and that any further intervention was dependent upon collaboration between the perinatal team (including the SCP), and the client. Following completion of the intervention, one participant met with the SCP to discuss further therapeutic work regarding bonding and attachment, and two participants stated they did not require further psychological support at that time due to reductions in distress.

2.11.5 Confidentiality and data protection. Pseudonyms were utilised ('Anna', 'Claire' and 'Ruby') and some contextual information in client case records were purposely kept vague to strengthen anonymity further. All participant data was treated as confidential and stored accordingly. This included psychometric measures, audio recordings of CI's and therapy sessions (kept on an NHS trust-approved encrypted memory stick), and participant demographic information. All data was stored in according with University of Lincoln and NHS trust regulations. Participants were assigned codes which were used on psychometric measures. Any personally identifiable information was restricted to the research team and administration staff at the University of Lincoln and these documents were stored appropriately in a locked filing cabinet in the Trent Doctorate of Clinical Psychology administrative office. All members of the research and administrative team endeavoured to abide by General Data Protection Regulation (GDPR) and the UK Data Protection Act 2018, in order to protect participants' right to privacy. Additionally, only minimum required information from participants was collected in order to answer the research question.

2.12 Measures[22] and rationale

2.12.1 Quantitative measures. According to Elliot (2002), quantitative self-report measures should be administered at the beginning and end of therapy as

[22] Not included in appendices due to copyright

a minimum, and ideally administered periodically throughout therapy. Although establishing a baseline was not integral to the original HSCED method (Elliott, 2002), Elliott (2009) later recommended that two baselines are obtained prior to the intervention starting. However, this could not be collected due to service practicalities, as individuals are not referred into the perinatal service until their second or third trimester, and as per the research question it was important to complete the intervention prior to birth.

Process measures. CFT-specific process measures were administered at the beginning of therapy and each session, to measure whether the intervention targeted therapy-related problems (guilt and shame, compassion). These were utilised as both pre/post therapy and weekly measures, to provide a pre-therapy score and to assist with session-specific process-outcome mapping.

***Other As Shamer Scale (OAS; Goss, Gilbert, & Allan, 1994)*.** The OAS scale is a measure of shame experienced by the individual due to how they perceive reactions and judgements from others (Gilbert, McEwan, Bellew, Mills, & Gale, 2009). Three distinct dimensions of shame are measured by the OAS; feeling inferior, feeling shameful by others' reactions, and feeling 'empty' (Goss, Gilbert, & Allan, 1994). The OAS has been found to be strongly associated with internal shame and moderately associated with other similar shame measures (Goss, Gilbert, & Allan, 1994). This measure is psychometrically valid in use within the British adult population, as per the participants for this research study (Goss, Gilbert, & Allan, 1994). This measure demonstrates temporal stability over a four to six week period, which suggests appropriate weekly use for this six-week intervention (Matos, Pinto-Gouveia, & Duarte, 2011), alongside a one factor structure providing 38% explanation of variance and strong internal consistency (Matos et al., 2011).
Measurement of external shame was considered important to this research study given that much guilt and shame experienced in the perinatal population arises from concerns they may be viewed by others as a 'bad mother' or 'should be' enjoying motherhood as per societal expectations (Nicholson, Sweeney, & Geller, 1998). Additionally, shame is one of the complaints targeted by CFT so

was a pertinent process to measure. This measure is the only published psychometric developed to assess external shame in accordance with evolutionary and biopsychosocial perspectives which are pivotal in CFT (Gilbert, 2009; Gilbert, 2010b). Guilt and shame are frequently discussed as a common pairing in psychological distress, as guilt regarding the way events and behaviour are appraised (e.g., “I’m a bad mother because…”) often leads to shame, as this is internalised (Tangney, 1998). However, as the experience of guilt is event-specific and therefore individualised, CFT aims to measure and target shame specifically. which is why psychometric measures of shame are used within existing CFT research rather than measures of guilt (e.g., Gilbert, 2000; Gilbert & Irons, 2005; Laithwaite, et al., 2009), as per this research study. However, as guilt and shame are incredibly difficult to completely separate clinically and within research, they are collectively referred to both in CFT literature and within this study.

The OAS measure was developed from the Internalised Shame Scale (Cook, 1988) and therefore items are re-worded to reflect expected judgements from others, for example “others see me as” (Gilbert, McEwan, Bellew, Mills, & Gale, 2009). Participants rate on a five-point scale (never, seldom, sometimes, frequently, almost always) the frequency with which certain evaluations are made, such as “I feel other people see me as not good enough.” All item scores are summed to provide a total OAS score, whilst higher scores indicate greater external shame (Gilbert et al., 2009).

The Compassionate Engagement and Action Scales (CEAS; Gilbert et al., 2017). This scale aims to measure an individual’s desire to engage with and act upon compassion towards others, from others, and towards themselves. The CEAS addresses wider theoretical conceptualisations of compassion and was developed in response to identified limitations of existing measures of compassion (Lindsey, 2017). Therefore, following investigation of numerous compassion measures, the CEAS is “recommended as the most appropriate measure for clinicians and researchers who wish to explore and measure compassion” (Lindsey, 2017, p.153-154). The full measure was completed pre and end of therapy. As defined by Gilbert (2009), the ability to

engage with and tolerate distress is an important factor, but a key aspect of compassion is in demonstrating the commitment and courage to act in a way that is helpful in alleviating the distress of others and the self, and to actively make behavioural changes (Lindsey, 2017). Subsequently, the 'action' subscales taken from the CEAS were completed each week to measure specific compassionate actions in dealing with distress, and therefore whether the participant was utilising skills from sessions. The decision to ask the participant to complete only the action subscales each session was also due to consideration of participant burden and prioritisation of measurement. It is deemed appropriate to use the single compassion factor scales within research, and utilisation of separate engagement and action subscales for more detailed explorations (Gilbert et al., 2017).

The CEAS contains reversed items in each of the three scales, which are included in an attempt to reduce response bias (Gilbert et al., 2017). Researchers are instructed to exclude these responses when calculating total score as they are regarded as 'fillers' to obscure face validity in reducing distortion of responses (Gilbert et al., 2017). Development of the measure using UK, Portuguese, and USA non-clinical populations reveal mean total scores for UK females as 72.51 (SD=15.67) for the 'compassion to others' subscale, 55.70 (SD=15.47) for the 'compassion from others' subscale, and 58.19 (SD=15.05) for the 'compassion for self' subscale (Gilbert et al., 2017). Correlations between all subscales for the CEAS have been found significant and positive (Gilbert et al., 2017). Additionally, for each specific focus of compassion (i.e. for others, from others, and for self), correlations between the engagement and action subscales are high (r=.67 to .83; Gilbert et al., 2017). Correlations between the different foci for compassion are moderate, with the strongest correlation pertaining to the 'compassion for self' engagement scale, with 'compassion to others' engagement scale, at .44. This suggests that there are moderate associations between differing compassion foci, and supports theory that individuals may be high in one form of compassion (often 'to others') but may be low in another form (often 'for self'), which is often reflected in clinical practice (Gilbert et al., 2017). Regarding the action subscales, the mean total

scores for UK non-clinical (combined gender) populations are 28.47 (SD=7.40) for the ‘compassion to others’ subscale, 23.07 (SD=6.96) for ‘from others’ subscale, and 24.01 (SD=8.18) for the ‘compassion for self’ subscale (Gilbert et al., 2017). The ‘compassion to others’ and ‘compassion from others’ scales load on two latent-first order factors, the ‘engagement’ factor and ‘actions’ factor (Gilbert et al., 2017, p.10), which also load on to a higher order factor of ‘compassion for others’ and ‘compassion from others.’ (Gilbert et al., 2017, p.10). Regarding the ‘compassion for self’ scale, a three-order factor has been established whereby items within the engagement subscale load on two latent first-order factors - emotional sensitivity to suffering and being moved by one’s suffering (comprising the first factor) and the remaining four items within the scale comprising of the second factor (Gilbert et al., 2017, p.10). Additionally, items within the ‘action’ subscale load onto the ’actions’ factor, whilst engagement and actions factors load onto a higher order factor within the ‘compassion for self’ scale. Temporal stability of the measure has also been deemed ‘good’, which was considered in selecting this as a weekly measure (Gilbert et al., 2017).

Reliable change and clinical caseness cut-offs were calculated using published norms from non-clinical samples (Gilbert et al., 2017; Lindsey, 2017). Clinical norms were approximated utilising standard deviations from the non-clinical sample in order to gain a clinical caseness cut-off (Lindsey, 2017), whilst reliable change calculations utilised non-clinical female UK samples due to lack of alpha coefficients published for action subscales in the Lindsey (2017) research paper (Gilbert et al., 2017).

Outcome measures. Outcome measures were completed pre and post therapy, with the CORE-5 completed each session, in order to assess client distress.

CORE-5 (Barkham, Hardy, & Mellor-Clark, 2010). CFT aims to reduce distress via targeting feelings of guilt and shame and increasing compassion (reflected in participant inclusion criteria). Therefore, a measure of distress was administered each session (CORE-5) to track recovery and fluctuations in participant distress, as per the research question. The CORE-5 comprises five

items including two positively-keyed items and three negatively-keyed items, in covering the domains of depression, anxiety, functioning (close relationships and generally), and subjective well-being (Barkham et al., 2010). When considering other CORE measures, this version was chosen to measure weekly distress whilst reducing burden on the client, due to the length of the CFT-specific measures. This shorter version of the CORE-10 (which extracts items from the original CORE-OM) is deemed most appropriate for monitoring and tracking change across weekly sessions (Barkham et al., 2010). It is advised that the CORE-5 is used on a weekly basis to assess change, rather than as only a pre/post measure due to the limited range of scores, which is why it was utilised as a weekly measure in aiding process-outcome mapping and assessing distress fluctuations (Barkham et al., 2010).

The alpha is reported as 0.81 with a SD of 9.33 (in comparison to a SD of 6.91 for the CORE-OM; Barkham et al., 2010). The items on the CORE-5 were evaluated against depression diagnosis and symptomology and revealed the area under the curve to be 0.92 (Barkham et al., 2010). Calculating the mean score allows comparisons to be made to clinical and non-clinical populations (Barkham et al., 2010). Although factor loadings and temporal stability have not been investigated for the CORE-5, data from the CORE-10 from which the CORE-5 was adapted, indicates high internal consistency and strong covariance across items rather than heavy contamination from random variance (Barkham et al., 2010). Additionally, although not supported by quantitative psychometric data, the CORE-10 is considered appropriately for weekly use whereas other measures such as the PHQ-9 (Kroenke, Spitzer, & Williams, 2001) and GAD-7 (Spitzer, Kroenke, Williams, & Löwe, 2006) have a 14-day time frame which indicates weekly use is inappropriate and reduces accuracy in change measurement (Barkham et al., 2010).

In analysing and representing data, the mean total score multiplied by ten was used as per author recommendations, as this allows comparison against other CORE instruments (Barkham et al., 2010).

Personal Questionnaire (PQ; Shapiro, 1961). The PQ was completed as an outcome measure to assess whether the intervention impacted upon personalised, subjective client-goals. The questions are worded as 'problems' and clinical experience dictated that these did not necessarily represent 'distress' as per the research question (e.g., "problems with partner"), yet provided useful information regarding the client's own goals, even if these were different from professional judgement. Additionally, it was acknowledged that the intervention itself may not have been able to reduce specific life stresses or worries, but rather aims to increase the client's compassion towards themselves (in particular) during periods of distress, in an effort to indirectly reduce distress. An advantage of using this measure was that each participant presented with a different clinical diagnosis and presenting difficulties (aside from guilt and shame), and this psychometric enables personalised therapeutic goals. Psychometric stability properties of the PQ have been investigated in ascertaining whether this is an appropriate pre and post measure. It has been found that this measure shows strong correlations with standardised outcome measures considering both between and within-participant levels, and is able to detect client change over weekly sessions and also the course of therapy (i.e. pre and post; Elliott et al., 2015). The internal consistency is considered good, with "pre-therapy between-client reliabilities a bit higher and more variable than within-client reliabilities" (Elliott et al., 2015, p.14).

Other measures.

Working Alliance Inventory – Observer – Short form (WAI-O-S; Tichenor & Hill, 1989). Extra-therapeutic processes (e.g., expectation of therapy) and common factors (e.g., the therapeutic relationship) are also measured as part of the HSCED process and in ascertaining *how* the client changed. Regarding measurement of the working alliance, the WAI-O-S was completed by a research supervisor, using audio recordings of sessions. This was used to provide a more objective, observational account of the therapeutic relationship. This measure was selected in an attempt to avoid ceiling effects which may be seen in other therapeutic alliance measures, particularly when completed by the therapist or client. Subsequently, an objective, observational

rating is likely to reduce researcher bias from the therapist, and participant bias or social desirability bias from participant (Seymour-Hyde, 2012).

The Working Alliance Inventory (Horvath & Greenberg, 1989) was created in an effort to measure the working alliance. Three versions were created to enable measurement from the therapist perspective (WAI-Therapist), the client (WAI-patient), and an observer (WAI-Observer). Tracey and Kokotovic (1989) developed an abbreviated version of the WAI which comprised of twelve items and was named the Working Alliance Inventory-Short form (WAI-S). Tichenor and Hill (1989) then adapted this abbreviated version of the WAI so that it could be used by an observer, thus creating the WAI-O-Short form. Internal consistency on the WAI-S compares favourably to that of the original longer form, and validity of this measure is supported by a significant relationship with client outcome measures (Martin, Garkse, & Davis, 2000; Tracey & Kokotovic, 1989). Subsequently, the WAI-O-S has been deemed useful to researchers and clinicians, particularly due to the relative ease of administering a 12-item measure. The factor structure of the WAI-O-S is also similar to the original WAI-O (Tracey & Kokotovic, 1989).

The WAI-O-S was utilised with the intention of reducing observer fatigue which may have influenced the accuracy of scoring and attention given to each aspect, and in contributing to existing relatively sparse literature for this measure.

As current literature is unresolved regarding the scoring system (e.g., Andrusyna, Tang, ReRubeis, & Luborksy, 2001; Gatta et al., 2010; Santirso, Martín-Fernández, Lila, Gracia, & Terreros, 2018), careful consideration was given as to the scoring system implemented in this study. This measure was scored by an observer, a member of the research team, whereby one ten-minute segment was taken from the first, middle, or end third of a session, as used in other research studies (Andrusyna et al., 2001; Ligiéro & Gelso, 2002). The rationale for this was as follows:

- Five-minute segments appeared more prone to error due to the manualisation of the therapy and utilisation of various exercises, risking the five- minute segment taken up with therapist explanation, with little input from the client. It was anticipated that this could have artificially deflated the average of the session ratings.
- Five-minute segments were deemed unlikely to be substantial in assessing or gaining evidence regarding the content and relationship occurring within the session.
- Considering these points and as the literature was largely unresolved in terms of the most effective method of scoring, a pragmatic decision of two ten-minute segments comprising of first, middle, and end segments of each session appeared reasonable and was appropriate in gaining required data.

2.11.2 Qualitative measures.

Change interview. A change interview (CI) was implemented as per HSCED guidance (Elliot, 2002) in order to gain qualitative data regarding the therapy and client, particularly concerning any helpful or unhelpful aspects of therapy and key events which occurred for the client. This aimed to support investigation regarding *how* the client changed.

The interviews were transcribed by the primary researcher, in order to increase familiarity with the data and to begin the process of categorisation (Bailey, 2008). Acknowledging the different levels and styles of transcription, a 'tidy style' was selected (Henderson, Gray, & Brocklehurst, 2007). This style incorporated rules of written grammar, for example, utilisation of commas and capital letters, to enable a user-friendly transcript. This was deemed appropriate due to the judges reading the transcripts to consider proposed categories, and as content was prioritised in answering the research question, rather than the 'structure of talk' (Bucholtz, 2007). Transcripts therefore recorded only complete words which were deemed necessary to the content, and did not record changes in vocalisation, pause, or repair (Henderson et al., 2007), particularly as discourse analysis was unnecessary and would likely have resulted in

increased risk of researcher bias. A semi-structured interview schedule was developed by the primary researcher and research team. This was rooted in Elliott's (2002) recommendations for open-ended questions and incorporated the HAT framework (Llewelyn, 1988), which provided rating scales to assist the client in reflecting upon helpful aspects of therapy. The HAT Framework was utilised in a conversational manner rather than as a complete measure. This was to reduce participant load so that the participant did not need to complete the full questionnaire every session, but enabled specific processes, events, and attributions to be queried. Please see Appendix J for the CI schedule.

2.12 Justification for intervention length

Currently, no specific recommendations or manuals exist regarding length or content of a CFT intervention, as existing research has ranged from group therapy (Braehler et al., 2013; Laithwaite et al., 2009) to individual therapy (Beaumont, Jenkins, & Galpin, 2012), delivered both face to face (Ashworth, Gracey, & Gilbert, 2011) and online or self-guided (Kelly et al., 2010; Sommers-Spijkerman, Trompetter, Schreurs, & Bohlmeijer, 2018). Session length in existing literature has ranged from, for example, 15 self-guided minutes per day for two weeks (Matos et al., 2017) to 24 sessions spanning ten weeks (Gale, Gilbert, Read, & Goss, 2014). Existing research has subsequently shown that fewer than six sessions lasting 1.5 hours have been effective in reducing client distress (Gilbert & Irons, 2005; Leiberg, Klimecki, & Singer, 2011; Shapira & Mongrain, 2010). In response to service pressures such as occurring within the perinatal team, and existing research, the research team decided that researching whether six sessions could be effective would offer a contribution to existing literature and clinical practice. A need for research into the development of intensive short-term CFT manualised interventions has also been recommended by researchers in response to increasing service limitations which have already been considered by CBT interventions, and to enable utilisation amongst wider contexts (Kirby, 2017; Leaviss & Uttley, 2015).

3.0 Extended Results

The journal paper summarises key components from the rich case summaries including therapist information, client contextual information, context surrounding the therapy process, and quantitative and qualitative data. This extended section elaborates on these aspects of the rich case summaries, specifically providing additional information and data on key transcriptions from the change interviews, evidence for and against changes in distress and client goals, evidence for and against changes in specific CFT processes, and the full affirmative and sceptic arguments. This data was provided to the judges as part of the adjudication process.

3.1 Further information on rich case records

3.1.1 Anna's rich case summary

Further contextual information. Anna gained A-Levels before going to university, but unfortunately had to "drop out" due to mental health problems. Anna said her mental health worsened during this time due to stress at university. She reported coping somewhat during this time due to utilisation of "unhealthy strategies" - suffering from bulimia nervosa and self-harming via cutting. Anna reported that she visited her GP and took anti-depressant medication. She also accessed a Step 4 psychology service whereby she described a "long and useful" course of CBT which spanned two years from referral including being on a waiting list. Anna said she still used some of these techniques and managed to change some of her behaviours, but that this had not helped over the last year when her mood worsened. Anna described the anxiety and depression "ebbing and flowing" over the years and had worsened within the last year due to work stress, which led to her becoming self-employed and freelancing. Anna accessed an Improving Access to Psychological Therapies (IAPT) service two years ago when her mood worsened but reported this was not helpful as "too vague." Due to her age, the pregnancy was not considered 'high risk', but additional scans and tests were undertaken throughout her pregnancy. Anna did not report any other physical health difficulties and remained active throughout her pregnancy, including jogging

multiple times per week and cycling to sessions up to 35 weeks pregnant. Anna had never been pregnant previously, to her knowledge. Although the pregnancy was planned, Anna and her husband had decided “it’s now or never” due to her age. Anna was fearful and resentful about “giving up her life” which she thoroughly enjoyed and was reluctant to reduce hobbies and relaxation due to her mental health difficulties.

Anna reported that her husband was caring but “lacked psychological understanding” and didn’t understand the importance of talking about their feelings. She said her parents lived locally and provided practical support but did not provide emotional support and mental health was not discussed within their family. Her family were not aware of her existing or previous mental health difficulties. However, Anna had lots of friends, including a close group (all of whom had children), with whom she felt able to share her feelings.

When drawing out her personal ‘affect regulation systems[23]’, Anna drew the ‘incentive/resource-focused system’ as very large, as she identified this motivated her through work and fitness. Her ‘threat-focused system’ was small-medium sized, as she felt disconnected from threatening feelings even though she acknowledged that she strongly felt the secondary emotions arising from this. Anna’s ‘affiliative-focused/compassion system’ was very tiny, as she felt like she was never content, soothed, or compassionate towards herself.

Adaptations to CFT protocol. A particular focus of the intervention was in encouraging Anna to connect with her emotions. She reported that she could not remember the last time she truly connected emotionally to an event or situation.

Anna described feeling disconnected from imagery so an attempt was made to balance utilising techniques which she could connect to and benefit from, versus encouraging her to challenge the mental barrier she experienced (“too

[23] combining psychoeducation and formulation whereby the threat system, drive system, and contentment system are outlined, and interactions described

emotional and fluffy"). Therefore, some imagery was used but slightly less than with the other two participants.

Client and therapy goals. Using the Personal Questionnaire (PQ), Anna generated her personal goals for therapy which were as follows:

1. Improve low mood and anxiety.
2. Become more excited about pregnancy.
3. Decrease worry about long-term coping.

The goals for Compassion-Focussed Therapy (CFT) across all clients are as follows:

1.) Increase compassion towards self, towards others, and allow from others (measured using the Compassionate Engagement and Action Scales; CEAS).
2.) Reduce feelings of guilt, shame, and self-criticising (measured using the Other As Shamer scale; OAS).

Additionally, as the goals for the therapy intervention were to reduce distress, this was measured weekly using the CORE-5 (assessing global functioning, including mood and interpersonal relationships).

Table 14 presents data both for and against each of these goals being met throughout the therapeutic intervention, with regards to the research question "has meaningful change occurred?"

Quantitative outcome measures. Anna's weekly measures are represented as line graphs in Figure 3 and Figure 4.

End of therapy measures were obtained at the end of session five in an effort to avoid collecting measures coinciding with a predictable 'dip' in scores relating to the final session before therapy ended (Owen, Drinane, Adelson, & Kopta, 2017). The WAI-O-S measure was completed retrospectively by a clinical psychologist (member of the research team) listening to audio recording of sessions.

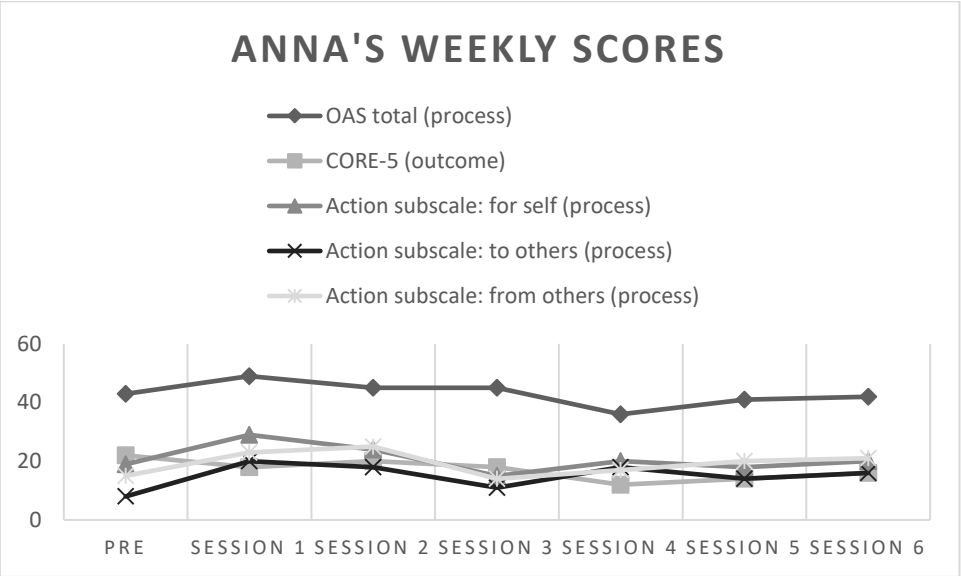

Figure 3. All weekly measure scores

Note. Higher scores indicate higher distress, higher shame, and less compassion. CEAS scores have been reversed for purpose of graph, and CORE-5 mean scores have been multiplied by 10 to enable ease of comparison with other measures.

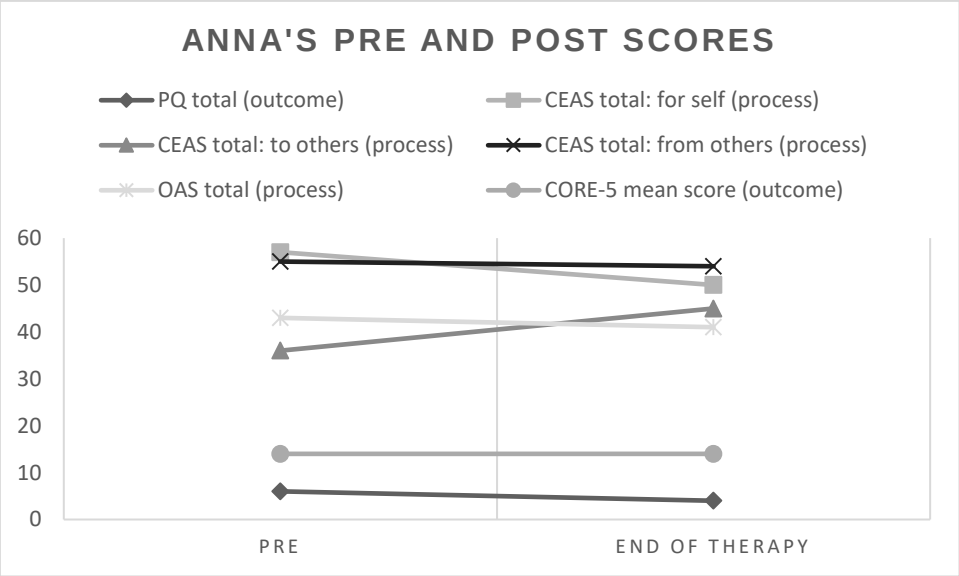

Figure 4. Anna's pre and end of therapy scores

Note. Higher scores indicate higher distress. CEAS scores have been reversed for purpose of graph, and CORE-5 mean scores have been multiplied by 10 for ease of comparisons against other measures.

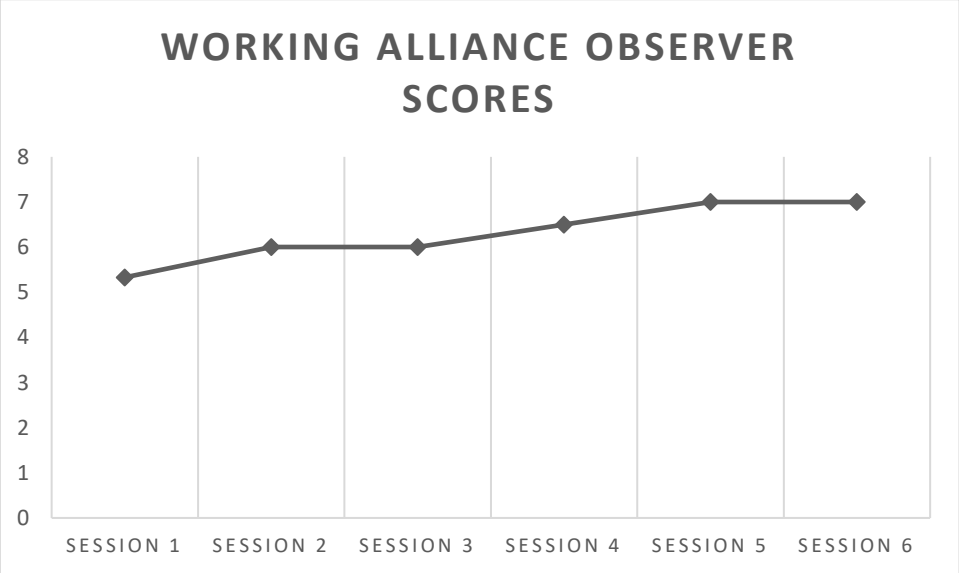

Figure 5. Working Alliance Inventory – Observer scores

Note. Higher scores indicate greater working alliance between therapist and client

Qualitative outcome assessment. Using the PQ, Anna reported specific difficulties which were bothering her at that time and specified how much each of these problems had been bothering her over the past week. At pre-treatment Anna rated low mood and anxiety as bothering her 'considerably,' felt that her lack of excitement about the pregnancy bothered her the maximum possible, and her worry about long-term coping bothered her 'very considerably.'

Towards the end of therapy, Anna rated her low mood and anxiety as bothering her 'moderately,' (an improvement from pre-therapy) her lack of excitement about the pregnancy bothered her 'considerably' (an improvement) and her worry about long-term coping had bothered her 'little' over that past week (an improvement).

Evidence for and against CFT-specific processes. Table 15 presents evidence for and against whether therapy was the cause of change, in response to the research question, "is therapy (generally) the cause of the reported changes?" This table also presents evidence in favour of the alternative argument, that any change is due to client's attributes or events occurring outside of therapy.

Table 16 presents evidence for and against change pertaining to the research question, "what specific events or processes brought about the reported changes?" This table highlights whether the participant reported specific CFT techniques or processes in assisting or hindering therapeutic change. It also presents evidence for and against changes in CFT-specific targeted processes: increase in compassion and decrease in guilt and shame. The refutational evidence proposes that any therapy would have enabled changes, or that the CFT intervention was hindering or ineffective.

Attributions have been suggested by the first author where appropriate in tables to assist with understanding and context.

Table 14.
Has meaningful change occurred?

Therapeutic goals	**Supporting evidence** *(meaningful change did occur)*	**Refutational evidence** *(meaningful change did not occur)*
Change generally	**Change interview** "I feel I'm in a better position almost to now start a process of doing, kind of thinking about compassionate based therapy" (129-130) **Simplified-PQ post-therapy evaluation** In response to the question, "at this point, how much do you really *feel* that the sessions helped you to manage your difficulties?" Anna scored 3 out of 7, indicating 'little.' This indicates some positive self-reported change.	**Change interview** "…kind of without the chance to practise it and I guess incorporate it into day-to-day life necessarily" (35-36) "…that when you need to read about things like the attributes of compassion and building this that and the other, I look at it and I see those words and they make sense in terms of a words point of view but I don't know what it means" (95-98) "…and then this bit over here about being compassionate which is a big jump for me still" (110-111)

	Therapist notes Session 3: After doing a compassionate-self imagery exercise, Anna said that she "feels like it is all making sense and becoming tangible and applicable." Anna said she felt that CFT therapy compliments her and her lifestyle, so has time to do and apply it even when stressed.	"I do wonder that you know, part of me not feeling it quite resonated it wasn't the right thing at the right time…but how much of that is psychologically where I am I guess, as well" (288-291) "…that kind of difficulty in processing it and practising that was probably one of my main observations" (331-332) "…it not including those bits of practise that would make it perhaps more meaningful to me, I think yeah made me feel like I didn't get the best out of it" (294-295) "…I'm still at the starting point, just that I'm a lot better informed now, rather than having gone down part of that journey" (131-133) "…that whole kind of translation about what it means for me emotionally, but also that's the bit I haven't quite

		worked out yet but yeah I still kinda feel is a bit lacking" (213-215) **CEAS: 'Compassion to others' score** Anna's 'compassion to others' score statistically significantly worsened from pre-therapy to end of therapy.
Improving low mood and anxiety	**Simplified-PQ pre and post measure** Reduction in PQ ratings of this problem Pre-therapy: score of 5 End of therapy: score of 4 **Change interview**	**Therapist process notes** Session 2: Anna drew her threat system as very large, describing her anxiety and low mood as overwhelming much of the time.

“Except there is the obvious you do it and the world doesn’t end and it’s okay” (221-222)

Therapist process notes

When practising the mindful breathing both in session and between sessions, Anna described this helping her to feel relaxed and noticing the changes in her body.

Session 4: Anna made conscious efforts to engage in mindfulness, which helped her feel more relaxed.

Session 5: Anna described noticing positive differences in her anxiety over the past week.

CORE-5 weekly scores[24]

Reduction in specific item pertaining to anxiety:

Pre-therapy: score of 10 out of 40

Session 1: score of 10 out of 40

Session 2: score of 10 out of 40

Session 3: score of 10 out of 40

Session 4: score of 0 out of 40

Session 5: score of 0 out of 40

Session 6: score of 0 out of 40

[24] Multiplied by 10, as per total score

Become more excited about pregnancy	**Simplified-PQ pre and post measure** Reduction in PQ ratings of this problem Pre-therapy: score of 7 End of therapy: score of 5 **Therapist process notes** Session 6: Anna said she felt relieved at planning on how to look after herself psychologically after the birth, and to maintain her hobbies and activities which "made her feel like her." She said it was important to her to plan time for herself and felt this was now possible.	**Therapist notes** During each session Anna reported feeling concerned about the fact she was not excited. She would bring examples each week regarding avoidance strategies she was implementing so that she "did not have to think about it" (referencing becoming a mother). Although in session four Anna stated she had started making preparations for the nursery, she acknowledged that this was because "it's getting a bit close now to keep avoiding it." In session five Anna referenced needing to go on holiday because she was stressed about the baby's arrival and wanted to continue avoiding making preparations. She also spoke in latter sessions of not wanting to give up her life as a childless adult.
Reduce worry about long-term coping and feel	**Simplified-PQ pre and post measure** Reduction in PQ ratings of this problem	**Change interview** "…my instant reaction in trying to do these things is more negative, cause yeah in that short-term it makes me feel

better able to cope	Pre-therapy: score of 6 End of therapy: score of 3 **Change interview** "…there's things about being kinder to yourself and asking for help and not seeing that as a failure, because there's so much going on, and physically I'm a lot less able to do it, that has made it although hard, much more permissible for me to do as well." (12-15) "…the bit I have noticed is what I was talking about before about being able	like I'm failing if I can't do that myself or whatever it is…" (175-177) "It doesn't mean I can go away and do it or feel it or whatever…" (204-205) **CORE-5 weekly scores[26]** Some increase in distress scores without any reported outside events by Anna: Pre-therapy: 22 out of 40 Session 1: 18 out of 40 Session 2: 20 out of 40 Session 3: 18 out of 20 Session 4: 12 out of 40

[26] Multiplied by 10, as per total score

to…being a bit more willing to ask for help." (55-56)

"…actually in terms with me being okay with that and kind of say well it's a good thing psychologically as well to sort myself out and emotionally and all that part as well, so things have changed…" (63-66)

"…we talked about the intent and things like that, that actually that doesn't necessarily matter because it's something that you're working towards." (100-102)

"I feel I'm in a better position almost to now start a process of doing…" (129)

Session 5: 14 out of 40

Session 6: 16 out of 40

Therapist process notes

Session 3: Anna described emotionally connecting to kindness and compassion as being scary because she was worried about a "tidal wave of emotions" and being "vulnerable."

CORE-5 weekly scores[25]

Some reduction over sessions in specific item pertaining to feelings of despair and hopelessness:

Pre-therapy: score of 20 out of 40

Session 1: score of 20 out of 40

Session 2: score of 20 out of 40

Session 3: score of 20 out of 40

Session 4: score of 10 out of 40

Session 5: score of 10 out of 40

Session 6: score of 20 out of 40

Therapist process notes

[25] Multiplied by 10, as per total score

	Session 3: Anna said she felt much more reassured when it was explained that it was fine for compassion to start at the cognitive level and then work toward truly feeling it in body and emotions. She had previously been worried about her ability to connect emotionally to the concept of compassion. Session 4: Anna appeared to emotionally connect to a distressing memory in the session and became a little tearful. Her beliefs about connecting emotionally were primarily her fear of feeling unable to cope with a "tidal wave of emotion."	
Overall score for PQ goals	**Simplified-PQ pre-therapy expectation** Anna's overall score from pre-therapy to end of therapy changed significantly, according to the reliable change minimum.	**Simplified-PQ end of therapy evaluation** In response to the question, "at this point, how much do you really *feel* that the sessions will help you to manage your difficulties?" Anna scored 5 out of 7, indicating 'considerably.' However, at the end of therapy, her post-therapy evaluation indicated that she only felt the sessions

		had helped her manage these difficulties “little.” This suggests the sessions did not help her as much as she had expected. **Simplified-PQ pre and end of therapy** Although significantly reduced, Anna’s score remained within the clinical caseness range at end of therapy.
Reduction of global distress	**CORE-5 weekly measure** Anna’s score improved statistically significantly from pre-therapy to end of therapy. **Therapist notes**	**CORE-5 weekly measure** Anna remained within clinical caseness throughout the intervention.

	Session 5: Anna described noticing positive differences in her anxiety and in the way she “speaks to herself.”
	Session 6: Anna was active in planning her short-term and long-term goals for continuing to use the techniques and how she might stay well, particularly for after the baby is born. She described feeling like it was possible to maintain this after the birth.

Table 15.

Is therapy (generally) the cause of the reported changes? (Or alternatively is any change due to client's attributes or events occurring outside of therapy?)

Supporting evidence (change is due to therapy)	**Refutational evidence** (changes due to external factors)
Change interview	**Change interview**
"…it's been suggested to me in the past, so it was something I had considered and was aware of that on quite a superficial level so…at least the concept wasn't foreign. The theoretical concept wasn't foreign, but it was on an emotional level, but I guess that probably put me in a helpful place to do that, yeah" (245-249)	"…there's also been an advantage to doing it now because there's things about being kinder to yourself and asking for help and not seeing that as a failure, because there's so much going on and physically I'm a lot less able to do it, that has made it although hard, much more permissible for me to do as well…" (11-15)
Attribution: client engaging with CFT	*Attribution: pregnancy (practicalities and motivation)*
"…from that outside perspective I think it feels a bit wishy-washy and I wasn't dead sure about it" (73-74)	"I would say that if I had been doing CFT whilst not pregnant then it would make it really, really hard." (52-53)
Attribution: change not due to expectancy effects	*Attribution: pregnancy (permission)*

	…“it’s incredibly hard to know whether it’s because of doing the CFT or just my situation, except for the fact that I have been able to justify it by being pregnant and justify it and tell myself it’s good and it’s good practise, so yeah that part of it has changed I guess…” (59-61) *Attribution: pregnancy (permission, practicalities, motivation)*
	“I had come into it at a point that I’d already started looking at some mindfulness stuff so already felt ready to start taking that next step or understanding that side more, so I think it kind of made that bit much easier to do because I was already…” (238-241) *Attribution: client’s research and mindfulness practice*

Table 16.

What specific events or processes brought about the reported changes?

Target	**Supporting evidence**	**Refutational evidence** (proposes that any therapy would have enabled changes or intervention was hindering/ineffective)
Specific CFT techniques	**Change interview** "…having done things in other therapies in the past, I found it more easier to do…" (25-26) "…wasn't too difficult to incorporate that compared to say when I've done CBT and you obviously having that real challenge and that can be really difficult. But to go away and practice some mindfulness which I've been trying to practise anyway, that's compassionate therapy and a very kind way to do it. I found it quite gentle in that respect." (28-32)	**Change interview** "…I do know equally that it was a good opportunity for me to be able to access some therapy now because it was an additional therapy rather than if Sophie hadn't been doing this I wouldn't be there…" (312-314) "…the main thing was that it was an opportunity that I think wouldn't have been there otherwise really…so if nothing else that reassurance that you're doing what you can in taking that opportunity" (321-326)

	"I think that the fact it wasn't task-heavy made it easier, or certainly not task-heavy in terms of emotionally challenging tasks and challenging your thought processes and all those kind of things." (39-41) "…it was a kinder, easier process to do than other therapies, and that might be due to my expectations based on my previous experiences where everything has to be horrible and challenging and you feel awful afterwards, but in that respect it felt fairly straightforward to take on." (44-47) "I didn't have those negatives I'd previously experienced in the sense that I didn't find it as challenging in a lot of the factors in that it was mainly going away and doing mindfulness	"there was a lot of information which I found quite hard to take in" (26-27) "…having all that information sometimes, it was not helpful, as opposed to unhelpful as a negative. But I didn't instantly see how it necessarily related like that old brain new brain stuff, for example. And I normally like theory, but I think sometimes that was a little bit too removed perhaps." (233-236) "…it felt perhaps it was a lot of the background of the background which perhaps almost felt a bit overwhelming when you know, you're trying to say what does this mean to me" (238-240) "…having weekly sessions felt quite a lot…it felt the next session came back round before I'd had chance to really do that…I think particularly if I hadn't been doing any

	practice which is a lot easier than other things." (73-76) *Attribution: CFT-specific model/approach* "…the couple of bits that resonated for me…one was looking at the formulation and, I'm trying to remember the names of them now, but about the fears and behaviours and the negative consequences of that…" (140-145) "…the other thing that I thought was good cause it was very clear…was the kind of teacher analogy. Cause I think it's very clear that you're, you know, very strict and giving yourself a hard time, compared to the more nurturing approach, which seems a bit barndoor obvious when you describe it like that, but yeah those parts were kind of the bits that made the most sense." (156-162)	type of mindfulness practise, there wasn't much opportunity to start getting into a habit with those kind of things. It just seemed to come round quite quickly." (255-263) "…not including those bits of practise that would make it perhaps more meaningful to me…" (294-295) "And I guess that's about being able to clearly identify that, so again using the CBT example, I guess when you work through you do so much practice and work through all those thoughts and I guess you can see things changing a little more." (111-114) "I was surprised there wasn't be more CFT-type practise…I guess if it was like other therapies it might have said okay take a situation here with this negative and this is your normal and what would happen here if

	Working alliance scores Anna's scores did not correspond with peaks and troughs in the therapeutic relationship, which suggests that any changes made were not due to the therapeutic relationship alone, if at all.	you inserted compassion and then how would that look, so yeah there's still that kind of carry-over I guess for me I need to work out and think about." (192-197) "Cause it felt to me like the practise of doing some of the mindfulness was quite separate from what I was understanding about CFT." (215-217) **Working alliance scores** Anna reported that the formulation process at the start of therapy was particularly helpful for her, yet this also corresponds with an increase in the therapeutic relationship.
Specific CFT process: Increasing compassion	**Therapist process notes** Session 1: Anna engaged well in the formulation process and seemed open and honest in exploring historical shaming experiences and	**Therapist process notes** Session 1: Anna said that although she could see how mindfulness could be helpful due to relaxation, she was still struggling to see how it would benefit her in terms of

	current difficulties. During the mindful breathing exercise, Anna said she felt more relaxed and her mind was “racing less.”	her formulation and presenting problem. During the mindfulness exercise, Anna found it difficult to connect with physical sensations and emotions.
	Attribute: Increasing mindfulness component and insight	
	Session 2: Anna requested additional input from the SCP, which could be due to self-compassion in considering what she needed, even though she said it was difficult discussing her own attachments and reservations about motherhood.	Session 2: Anna found it very difficult to emotionally connect and notice where she felt things in her body. She described feeling much more connected to the rational/descriptive behaviours than the emotional and physical reaction.
	Session 4: Anna demonstrated insight in considering the evolutionary and behavioural functions of emotions. Anna became a little tearful in the session which may reflect connection to emotions and tolerating this distress.	Session 3: Anna described “reading the words but don’t connect emotionally.” She said she couldn’t remember the last time she was truly emotionally connected to something. Anna described feeling fearful of “letting compassion in because then what else comes in?” She described finding it difficult to emotionally connect to being compassionate towards others and described

	"knowing what to do and how to act by following a learned response or script."
Session 5: Anna described noticing positive differences in her anxiety and in the way she "speaks to herself." She said she connected to the 'two teachers' example last session which helped her connect with self-compassion in particular. Anna specified the features of her compassionate-self and related to a strong, assertive version of herself and said the conversations really helped her connect to the idea of compassion. Anna said she had made a commitment to do things differently to reduce her mental distress (planning compassionate behaviour). Anna said it was "making more and more sense" and the analogies and examples were helpful. Anna said CFT is a positive thing for her and a	Session 4: Anna described the compassionate-self as being "fluffy" and unable to relate to it. Session 5: Anna said she was not sure whether the differences she noticed were due to the CFT techniques, or mindfulness activities that she was already doing prior to therapy. She said she "hates imagery" and doesn't connect to it. Anna was quite adamant about this even when it was suggested this could change with practise. Anna still made reference to compassion being "fluffy" and "woolly" and occasionally rolled her eyes when talking about being compassionate, particularly towards herself.

	“good fit” as it aims to increase qualities she already possesses. Session 6: Anna said that she has noticed changes, for example, asking other people for help and trying to avoid getting into the ‘vicious cycle.’ Anna was able to explain her formulation in a compassionate way. Anna said she was going to pursue further practice of compassion and mindfulness as part of her short-term and long-term goals following therapy. She said therapy helped challenge her preconceptions around mindfulness and compassion, to something more relatable and tangible. **CEAS scores**	Session 6: Anna reported potentially only making changes because “she was doing it anyway.” Anna described still “seeing words on the page but not connecting” with regards to attributes and application of compassion. **CEAS scores** Anna’s score for ‘compassion to others’ significantly worsened from pre-therapy to end of therapy.

	Anna's subscale score for 'compassion for self' improved from pre-therapy to end of therapy.	
Specific CFT process: Decreasing guilt and shame	**Therapist process notes** Session 1: When speaking about pertinent emotional shame memories during formulation, Anna's body language appeared quite relaxed, and she spoke openly of these experiences. Session 2: Anna requested additional therapy with the SCP regarding attachment with the baby, which may be due to a decrease in guilt and shame in talking about this. Session 4: Anna was able to describe the function of emotions in a non-judgemental way, reflecting on her own emotive states. Anna did not verbally	**Change interview** "…it doesn't feel very nice or letting other people be kind to me doesn't necessarily feel very nice and it has negative repercussions or impact…" (166-168) **Therapist process notes** Session 1: During the formulation process, Anna frequently referenced 'should's and ought's' regarding how to feel and behave. She expressed that she felt guilty at the antenatal classes when not feeling excited about becoming a mother.

chastise herself or apologise for becoming a little tearful in the session.	Anna said that her reservations about being a mother were too shameful to discuss with anybody else, including her husband, friends, and family members.
Session 6: Anna verbally described her formulation in a compassionate way and both her verbal and non-verbal communication did not appear to reflect feelings of guilt and shame regarding this.	Session 2: Anna requested additional therapy with the SCP but did not inform me, potentially exhibiting shame around this.
OAS score Anna's perceived shame from others score (OAS) improved from pre-therapy to end of therapy, although not statistically or clinically significantly.	Session 3: Anna described "feeling awful" that she was unable to connect emotionally to personal events or when friends were distressed. Session 5: Anna's repeated comments about compassion being "fluffy" and "woolly" and rolling her eyes, which may represent shame regarding the idea of being self-compassionate (in particular) due to her early shaming experiences.

	Session 6: Anna appeared to belittle any achievements over therapy.

Qualitative information about helpful aspects. This section pertains to aspects within therapy the participant identified as being helpful, and/or aspects outside of therapy that particularly contributed to change. The CI assisted in identifying and exploring significant events which occurred in therapy and were deemed important by the client, by using the HAT form to guide questioning. This data is described in Table 17. The bracketed numbers at the end of the quote indicates the line number from the original transcript. However, as the HAT form was used in a conversational manner, some answers were inferred rather than explicit answers to the questions presented in the table, as not all questions in the HAT were explicitly asked by the interviewer but answers were provided by the participant during the conversation.

Other factors deemed important in the therapy by Anna included the impact of being pregnant during therapy. Anna repeatedly referenced in the change interview and during sessions that pregnancy gave her permission to be kinder and more compassionate towards herself as she was "able to justify it by being pregnant and justify it and tell myself it's good and it's good practise." Additionally, as Anna was heavily pregnant during this therapy, she stated in sessions and the interview that as she was physically less able to engage in chores, she felt more able to ask for help. Additionally, Anna stated in sessions that due to her anxiety regarding becoming a mother, she was subsequently avoiding preparing the nursery and would engage in activities she enjoyed such as walking. This provided the opportunity to engage in mindful exercising which Anna said helped her relax and temporarily reduced her anxiety. In this way, the pregnancy served to perpetuate avoidance of infant-related tasks yet also provided opportunity to engage in mindfulness which Anna said she found beneficial. However, in the change interview, Anna described "pros and cons" to being pregnant during therapy and stated that "there's been lots going on and it's been harder to get the time and thinking space". Anna referenced mindfulness in the change interview as something she found particularly helpful, and also described CFT as "a very gentle" therapy and "it felt fairly straightforward to take on" which she compared favourably to CBT.

Table 17.

Helpful aspects of therapy identified at post-treatment change interview

Change and participant narrative	**Time spent on this aspect** (according to participant)	**Why participant felt it was important**	**How important**
1) CFT formulation "looking at the formulation and, I'm trying to remember the names of them now, but about the fears and behaviours and the negative consequences of that, and that feedback"	"a bit more towards the end, [session] 4 or 5 I think" "I wouldn't know how much time but I don't think it was overly dwelled upon, neither was it done too quickly"	"I think it was much clearer to see the value and to be able to say ah yes well if I put it into practise then that's not just being nice for the sake of being nice" "I mean obviously as I say I understand the reason because it's all evidence-based, but it's just that kind of thing about well what does that mean to	Moderately helpful (7 out of 9)

		me, or my instant reaction in trying to do these things is more negative, cause yeah in that short-term it makes me feel like I'm failing if I can't do that myself or whatever it is"	
2) Teacher analogy "I thought was good cause it was very clear but perhaps didn't help me translate it as much to me then, and again something I mentioned to Sophie, was the kind of teacher analogy. Cause I think it's very clear that you're, you know, very strict and giving yourself a hard time, compared to the more nurturing approach, which seems a bit barndoor	"I think the teacher bit, whilst it's a really good example for me and made perfect sense, it still doesn't let me be kind to myself" [interviewer than chose not to ask further questions on this and focused on CFT formulation]	[not asked in interview]	[not asked in interview]

obvious when you describe it like
that”

Arguments for Anna's case. The arguments below summarise and are assisted by, Figures 3-5 and Tables 14-17 which provide evidence for and against change occurring, attribution to therapy, and the relevance of any specific events occurring within or outside of therapy.

Affirmative case. The *affirmative case* proposes that there are clear links between therapy process and outcome, and requires at least two of the following pieces of evidence, as outlined by Elliott (2002): 1) change in stable client problems (client experiences changes in long-standing or chronic difficulties), 2) retrospective attribution, 3) outcome-process mapping (content of the change interview plausibly matching specific events, aspects, or processes within therapy), 4) event-shift sequences (significant therapy events are followed forward in time for evidence of their later effects e.g., stable shifts in client distress).

Any relevant factors as named above plus additional evidence relevant for Anna will be explored below in further detail.

Changes across therapy. The affirmative case first requires that there have been substantial changes in Anna's problems.

Anna's scores changed statistically significantly on the PQ, CORE-5, and 'compassion for self' subscale within the CEAS. This subscale change is of particular interest as CFT particularly aims to increase this attribute.
The pattern of Anna's distress on the CORE-5 measure may have been due to the process of beginning to emotionally connect to painful memories and exploring barriers to compassion, rather than Anna continuing to numb her emotions as a safety behaviour. In the first two sessions there was an emphasis on exploring current difficulties and trying to understand how these developed based on past experiences. Anna described this process as being frightening and difficult for her, which may explain her increasing distress scores during this time. Additionally, without the emotional detachment and with the focus on increasing sensitivity to thoughts, feelings and physical sensations, Anna may have started reporting her distress more accurately as she was more attuned with it, thus resulting in fluctuating distress levels. Anna spoke in sessions about

deep-rooted shame she experienced arising from asking others for help, and also referenced these difficulties in the CI. Although CFT aims to reduce feelings of guilt and shame, Anna's family perpetuated this narrative around avoidance of expressions of emotion (particularly sadness) or asking for help, so although the shame scores were variable over the course of therapy, it was acknowledged that Anna's ability to discuss her experiences and feelings openly was a huge improvement, yet not captured by the measures or PQ goals (particularly given that these discourses were present throughout her entire life).

Retrospective attribution. If there has been substantial change, retrospective attribution requires the client to attribute any changes they noticed to the therapy, which is highlighted in the change interview, and particularly explored when the client is asked about how likely they think the change would have been without therapy. Anna said in the change interview that she had noticed improvements which were potentially due to therapy.

*Therapist attributed these changes to the therapy***.** It may be helpful to consider whether the therapist attributed any changes to the therapy using knowledge of the client, and presentation and discussion within sessions. It was interesting that during sessions and in the CI Anna voiced that she wasn't sure whether she had changed "due to things I was doing already." However, the assessment process highlighted that Anna's difficulties were chronic and pervasive. Although baseline scores could not be obtained, Anna's process scores from pre-therapy (assessment session) to session one (obtained at the beginning of the session) largely worsened, which may indicate that improvements were not made prior to the therapy. When discussing mindful activities, Anna stated in the session that she was "already doing that without realising" yet a core aspect of mindfulness is the intent to purposefully engage in one activity so mindfulness may not have been entirely utilised until introduced within the CFT intervention.

Anna reported in the change interview that she perhaps required additional time to practise the techniques and see whether changes had actually been made.

*Process-outcome mapping***.** Process-outcome mapping refers to the client's change interview information about significant events corresponding with aspects or processes within therapy. Anna stated that the formulation[27] was particularly helpful for her, which was started in session one and discussed in more detail in session two. Therefore, it would be expected that Anna's scores may have improved at the beginning of session three. Anna's 'compassionate action towards self' score, 'compassionate action towards others' score, 'compassionate action from others' score, and CORE-5 score all improved at session three, and this session provided the most improved scores achieved once the intervention began. Both Anna's 'compassion to self' and CORE-5 scores statistically improved pre-post therapy, which may highlight the role of self-compassion in reducing distress.

*Change in stable problems***.** Baseline scores could not be obtained, but in the assessment session Anna described her difficulties as having occurred for over 20 years, with little improvement. She stated that she experienced small benefit from engaging in CBT in her 20's. It can be assumed that the therapeutic intervention is responsible for change when this occurs in chronic, pervasive difficulties. Anna described experiencing a change in her ability to ask for help and in being kinder to herself. Anna's PQ total score and 'compassion for self' subscale score changed significantly according to the reliable change index. The compassion score in particular, was a big change for Anna when considering that she appeared to resist the notion of compassion throughout the majority of therapy.

*Changes not due to relational artefacts***.** It did not appear that changes were due to relational artefacts (the client emphasising change to please the therapist) as Anna did not mention the therapist or therapeutic relationship during the change interview. It felt as though the therapeutic relationship was variable and occasionally that Anna did not relate to the therapist or possibly felt misunderstood. However, the working alliance scores suggest that the therapeutic relationship remained strong throughout therapy with a steady

[27] Please see Appendix H

increase over time. Nonetheless, as none of Anna's outcome or process scores mimicked this pattern, it can be assumed that the therapeutic relationship was therefore not wholly responsible, if at all, for creating change.

*Changes not due to expectancy artefacts***.** This pertains to whether changes occurred due to the client's expectation or hope for change. Anna described fewer changes in the CI than occurred according to her scores. Additionally, in the CI she often described her expectations of therapy being different to the reality and appeared disappointed in the amount of change which occurred. Therefore, changes are unlikely due to expectancy artefacts.

*Statistical artefacts***.** There may have been errors in the calculation of the reliable change minimum and clinical cut-offs, particularly as calculation of these were dependent upon data from other research papers. Additionally, all clinical caseness cut-off scores, except for the PQ score, are approximate due to lack of official guidance regarding this and have therefore been calculated using existing means for clinical and/or nonclinical populations. Therefore, the affirmative case suggests that type II errors could be responsible for lack of significant change in measures.

Anna commented that some of the wording in the questionnaires was confusing, particularly where negatively worded questions were used in the CEAS, which may have resulted in inaccuracy in capturing her experiences and may explain why significant change was absent in most measures.

Conclusion. This affirmative case stipulates that:

- Anna demonstrated substantial change in her problems.
- Anna attributed these changes to therapy, even if her scores did not immediately correspond with significant sessions.
- The therapist attributed most of these changes to therapy.
- This evidence contradicts sceptic non-therapy reasons for change and/or lack of change.

This evidence provides a basis for you to:

1. Support the case that Anna changed substantially during the period of therapy; and

2. Draw the inference that this change was caused by Anna's participation in the CFT intervention.

Sceptic Case. The sceptic case describes a good faith attempt to counter the argument that Anna changed substantially during therapy or that this change was due to the CFT intervention. In order to do this, the sceptic case will systematically examine the client's case record for evidence of alternative explanations, as suggested by Elliott (2002).

The following explanations suggest that any observed changes do not represent clinical or statistical improvement: 1) trivial or negative changes on measurement, 2) statistical artefacts, 3) relational artefacts, and 4) expectancy artefacts. Any relevant pieces of evidence will be explored below.

Trivial or negative changes on measurement. Anna's problems were not stable and baseline scores could not be established. Subsequently, Anna's pre-therapy scores are not sufficient alone to establish whether the distress she experienced would have remained stable at severe levels over time, or whether distress and compassion would have naturally improved as Anna neared her due date. On the measures where Anna was initially considered to be within the clinical range, she remained within the clinical range for all these at end of therapy. Although Anna's 'compassion for self' score significantly improved, all but one CFT subscale did not improve, which may suggest that the processes underlying CFT are not enough to result in distress changes. Anna's 'compassionate action to others' score statistically significantly worsened from pre-therapy to end of therapy.

Statistical artefacts. Statistical errors can't be ruled out and are based on other papers/means so rely on initial analysis being accurate. Therefore, the presence of a statistically significant change in PQ and CORE-5 scores could be due to statistical inaccuracy. Additionally, it could be possible that Anna misinterpreted the wording of questions in the PQ or CORE-5 or completed the measure in a way which inflated apparent improvement.

*Relational artefacts***.** Elliott (2002) suggests this can be evaluated by careful assessment of specific changes in the client's experiences i.e. whether the client's report in the CI represented score changes or whether it could have been due to a desire to impress or reassure the therapist. Interestingly, although Anna reported finding the formulation process and teacher analogy helpful, this was not represented in all subsequent scores, and any improvements were not stabilised. Additionally, the sessions where the formulation was completed correspond with an increase in the therapeutic relationship. Therefore, it may have been the increase in working alliance which resulted in the attribution that this technique was helpful. Direction of causation is unclear however, as a strengthening therapeutic relationship may have enabled the formulation process to be particularly effective for Anna. This is also true when considering that Anna found the 'two teachers' metaphor particularly helpful, yet this also coincided with steady improvement in the therapeutic relationship.

*Expectancy artefacts***.** In response to the question, "at this point, how much do you really *feel* that the sessions will help you to manage your difficulties?" Anna scored 5 out of 7, indicating 'considerably.' This indicates a relatively high expectation for therapy being beneficial. Additionally, in the change interview Anna described, "that reassurance that you're doing what you can in taking that opportunity" which may have led to a strong motivation for improvement if this was considered her 'only chance.'

The following explanations as suggested by Elliott (2002) stipulate that change has occurred but not due to therapy and is therefore due to the following factors: 5) self-correction, 6) life events, 7) psychobiological factors, and 8) reactive effects of research participation.

*Self-correction and other factors***.** This potential reason for change suggests that any improvement is caused by self-help outside of therapy and can be investigated by consideration of the participant's response in the CI when asked whether it would have happened without therapy. During assessment Anna spoke of researching mindfulness practise and that a close

friend was a mindfulness practitioner, and Anna reported that she found mindfulness very helpful. It is possible that this alone may have resulted in a reduction of distress. Consequently, although it would have been expected that Anna's scores would have improved from pre-therapy to session one, Anna described only recently having started to explore mindfulness, so it is possible that over time she would have become more skilful in this and experienced similar benefits. Anna also reported having a close group of friends who she may have felt more able to confide in regarding her anxiety/lack of excitement about the pregnancy, as the birth date neared. Although Anna reported that her friends never spoke of their own similar experiences, it is impossible to predict whether this would have happened closer to the birth.

*Life events***.** Anna went on holiday between sessions four and five, which resulted in some scores improving ('compassionate action towards self' and 'compassionate action towards others'). Therefore, some improvements may have been due to this rather than the session content or therapy itself. Additionally, there may have been additional factors which improved Anna's mood or ability to be compassionate, yet she did not report these in session or in the change interview. For example, Anna reported in the change interview that she felt more able to ask for help when pregnant due to physical inability to do things and that it subsequently became permissible. It is therefore possible that there were instances where Anna was unable to do things and asked for help between sessions, whereby she allowed herself to be compassionate via rationalisation. However, her OAS score also increased in session five, implying that this was accompanied by feelings of shame.

Psychobiological factors. Although not reported by Anna, changes in hormones may have contributed to fluctuated in mood, distress, or compassion. Although her scores did not consistently change towards the end of pregnancy or demonstrate stable patterns, Anna did report fluctuations in physical discomfort and concentration which may have accounted for any relative peaks in her scores, particularly as fluctuations indicating improvement were not statistically significant week-to-week.

*Reactive effects of research participation***.** Anna described a familiarity with the research process and questionnaires during her change interview but did not state whether this had a positive or negative impact on her experience. However, Anna did describe a desire to take part due to being "under the threshold" for therapy within the perinatal service and an opportunity that she would not have otherwise had.

*Improvements not maintained despite life stressors***.** Follow-up data had not yet been collected at the judicial stage to assess whether incubation effects existed. Anna often spoke of feeling anxious about becoming a mother and did not notice any changes in this (nor did the therapist). However, her distress, compassion and shame scores fluctuated throughout the intervention. If the intervention had been truly effective, it would be expected that stable changes would occur despite these difficulties.

*Lack of event-shift sequences***.** Any changes were not sustained as Anna's scores across all measures appeared to fluctuate throughout the intervention. It would be expected that significant therapy events would result in significant shifts in difficulties, yet only weak evidence exists for event-shift sequences in Anna's therapy, because sustained reliable shifts did not occur when coinciding with helpful events as per Anna's change interview. Anna identified the formulation process in session one and session two as particularly helpful, alongside the teacher analogy which was discussed in session four (to a lesser extent), although Anna's subsequent scores did not reflect this and comprised of both increases and decreases.

*Client ambivalence about reasons for change***.** Anna was unsure whether she had changed as a result of the therapy or if it would have occurred regardless, “it’s incredibly hard to know whether it’s because of doing the CFT or just my situation.” Unfortunately, when asked in the interview whether changes would have occurred without therapy, Anna did not directly answer this question.

Conclusion. This sceptic case stipulates that:

- Anna did not make significant improved changes.
- Anna did not attribute these changes to therapy.
- Any minor changes made were due to extra-therapeutic factors.
- This evidence contradicts evidence presented by the affirmative case.

This evidence provides a basis for you to:

1. Reject the case that Anna changed substantially during the period of therapy; and

2. Draw the inference that any change was caused by extra-therapeutic factors.

3.1.2 Claire’s rich case summary

Further contextual information. Claire was unemployed just prior to the pregnancy, and co-habiting with the father of her unborn child. Claire had two other children who were of primary school age. Claire had an undergraduate degree and a PGCE and had previously worked as a teacher. Claire had gestational diabetes during the pregnancy and was therefore considered high risk. The pregnancy was planned but Claire described feeling constantly worried, particularly about the gestational diabetes and potential impact this was having on the baby. She said that the baby’s weight had been fluctuating each week which was anxiety-provoking and unpredictable. Claire had not experienced any other pregnancies aside from her three children.
Claire reported suffering with depression during and following her previous two pregnancies and had experienced depression and an eating disorder as a teenager. Claire stated, “ I always have been a very anxious person.” Claire had

received regular support from a community psychiatric nurse from the perinatal service following the birth of her second child due to postnatal depression, and had received contact with a psychiatrist during this time for psychiatric medication. As a teenager suffering from an eating disorder, Anna met frequently with the school nurse and had support from the Child and Adolescent Mental Health Team, both of which she found helpful. When asked about previous trauma, Claire described an emotionally abusive relationship with the father of her other two children. She said he was “controlling and nasty” and left Claire when she was pregnant with their second child.

Claire described her family as providing practical support but that they would never discuss mental health difficulties. She said her partner was helpful and supportive but didn’t seem to understand her mental health difficulties. She was continuing to see a community psychiatric nurse from the perinatal team every fortnight and found this helpful. She also had a group of friends but said she didn’t have much time to see them.

A particular focus of the intervention was in encouraging Claire to talk about her experiences and to explore these. Claire acknowledged that it was a challenge attending the sessions on a weekly basis due to practical and emotional reasons.

When drawing out her personal affect regulation systems, Claire drew her ‘threat-focused system’ as very large due to the anxiety and depression, and her ‘incentive-focused system’ as small-medium as she always felt busy and committed herself to additional projects. Claire initially drew her ‘affiliative-focused/compassion system’ as medium-large sized as she said she was able to feel safe, content, and soothed when she spent time with her children. However, when she considered this in the context of being alone, Claire drew it as very small, as she said she relied on her children in order to do this.

Adaptations to the CFT protocol. Claire required additional time and prompts to consider her responses to questions as she voiced finding it difficult and strange to consider what her thoughts, feelings, and bodily sensations were, particularly retrospectively. Therefore, questions were re-worded and additional prompts used to assist her in these reflections.

Client and therapy goals. Using the Personal Questionnaire, Claire generated her personal goals for therapy which were as follows:

1. Feel more able to cope with everyday life.
2. Feel less anxious.
3. Feel less guilty when I can't do things with the children.

The goals for CFT across all clients are as follows:

1. Increase compassion towards self, towards others, and allow from others (measured using the Compassionate Engagement and Action Scales).
2. Reduce feelings of guilt, shame, and self-criticising (measured using the Other As Shamer scale).

Additionally, as the goals for the therapy intervention were to reduce distress, this was measured weekly using the CORE-5 (assessing global functioning, including mood and interpersonal relationships).

Table 18 below presents data both for and against each of these goals being met throughout the therapeutic intervention, with regards to the research question "has meaningful change occurred?"

Claire's quantitative outcome measures. Claire's weekly measures are represented as line graphs in Figure 6 and Figure 7.

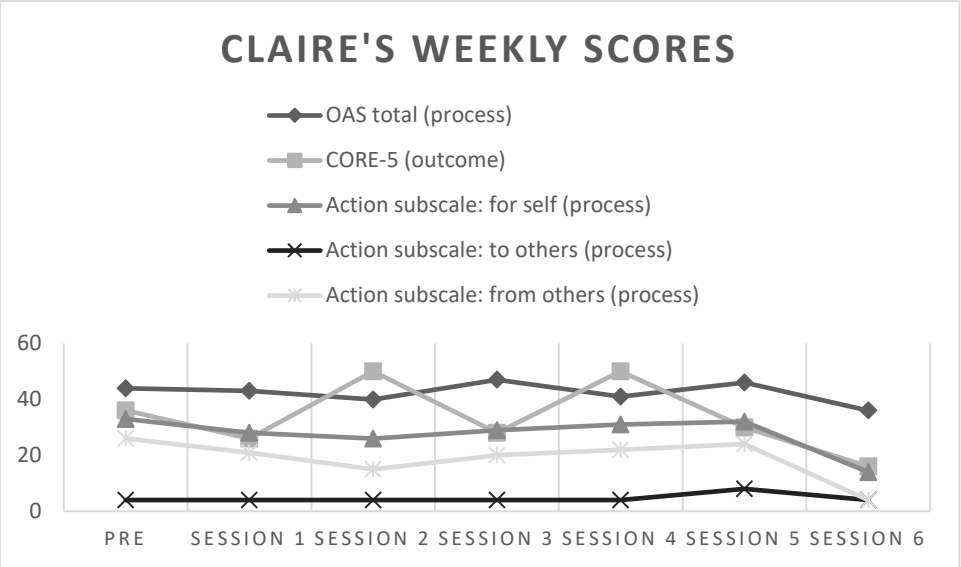

Figure 6. All weekly measure scores

Note. Higher scores indicate higher distress, higher shame, and less compassion. CEAS scores have been reversed for purpose of graph, and CORE-5 mean scores have been multiplied by 10 to enable ease of comparison with other measures.

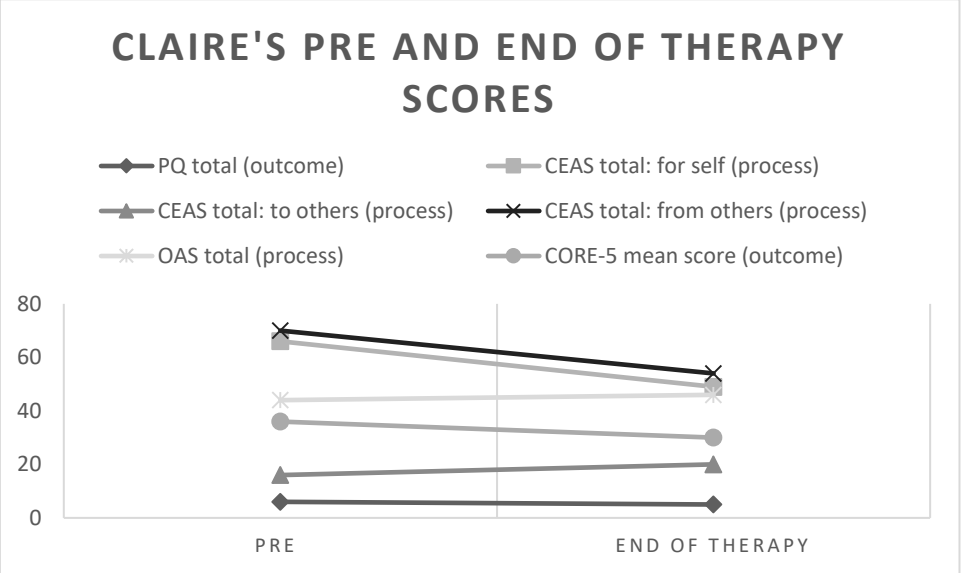

Figure 7. Claire's pre and end of therapy scores

Note. Higher scores indicate higher distress. CORE-5 mean scores have been multiplied by 10 for purpose of graph. CEAS scores have been reversed on graph for ease of comparisons against measures.

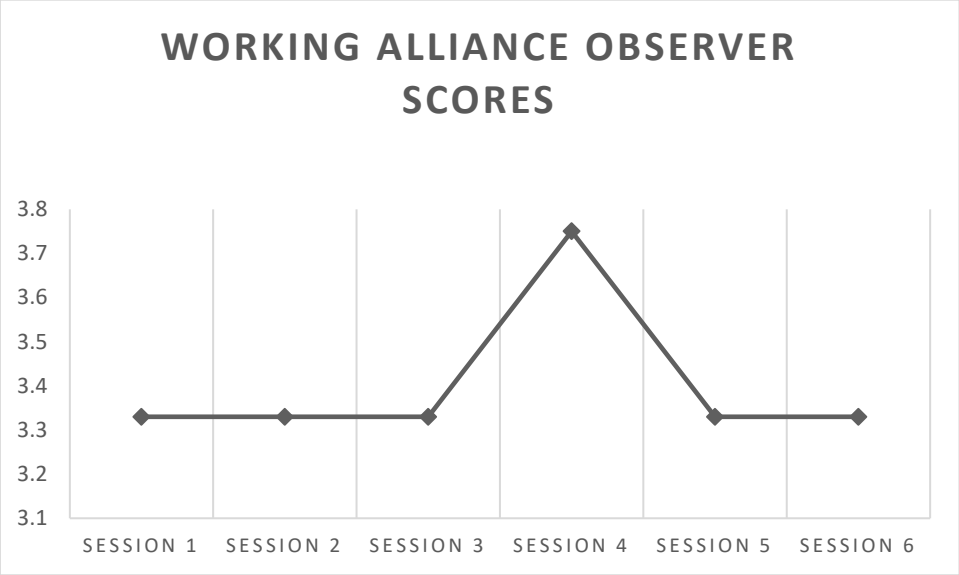

Figure 8. Working Alliance Inventory – Observer scores

Note. Higher scores indicate greater working alliance between therapist and client

***Qualitative outcome assessment*.** Using the PQ, Claire reported specific difficulties which were bothering her at that time and specified how much each of these problems had been bothering her over the past week. At pre-treatment Claire rated “feeling like I can’t cope with everyday life” as bothering her ‘very considerably,’ “feeling anxious, on edge and worn out”

bothered her ‘very considerably,’ and “feeling guilty that the children are off school but feel unable to do things” bothered her ‘very considerably.’

Towards the end of therapy, Claire rated “feeling like I can’t cope with everyday life” as bothering her ‘very considerably’ (same as pre-therapy) anxiety, “feeling anxious, on edge and worn out” bothered her ‘considerably’ (a decrease) and “feeling guilty that the children are off school but feel unable to do things” as bothering her ‘moderately’ (a decrease).
At the change interview, Claire was asked to describe any changes she had noted in herself over the intervention, which are presented in Table 18. Regarding any changes she noticed, Claire was asked to consider whether she expected the change, how important that aspect was for her over the course of therapy, and how likely she felt the change would have been without the therapeutic intervention.

Table 18 presents data both for and against each of these goals being met throughout the therapeutic intervention, with regards to the research question “has meaningful change occurred?”

***Evidence for and against CFT-specific processes*.** Table 18 presents evidence for and against whether therapy was the cause of change, in response to the research question, “is therapy (generally) the cause of the reported changes?” This table also presents evidence in favour of the alternative argument that any change is due to client’s attributes or events occurring outside of therapy.
Table 20 presents evidence for and against change pertaining to the research question, “what specific events or processes brought about the reported changes?” This table highlights whether the participant reported specific CFT techniques or processes in assisting or hindering therapeutic change. It also presents evidence for and against changes in CFT-specific targeted processes: increase in compassion and decrease in guilt and shame. The refutational evidence proposes that any therapy would have enabled changes, or the CFT intervention was hindering or ineffective.

Attributions have been suggested by the first author where appropriate in tables to assist with understanding and context.

Table 18.
Has meaningful change occurred?

Therapeutic goals	Supporting evidence	Refutational evidence
Change generally	**Simplified-PQ pre-therapy expectation** At the end of therapy, Claire's post-therapy evaluation indicated that felt the sessions had helped her manage these difficulties "moderately" (4 out of 7). Claire then added "this has potential to be higher if I keep practising as it takes time." This suggests that although the sessions didn't help her quite as much as she had expected, they had helped her, and had the potential to help her more so once she had time to practise and apply the techniques. **Change interview**	**Therapist notes** Although Claire had understandable anxiety surrounding her hospital appointments, her distress subsequently increased substantially as a result of this. It would be hoped that CFT could protect against this distress, particularly in later sessions, but even her reported use of compassion techniques could not decrease this distress. **Measures** Three out measures statistically significantly worsened pre-post therapy.

In response to the question “Was there anything that you hoped therapy might help with but didn’t?” Claire answered “no” (46)

“How I’ve been thinking I think has changed…” (23)

Measures

Three measures improved from pre-therapy to end of therapy.

CORE-5

Claire’s CORE-5 score improved from pre-therapy to end of therapy, even though she stated when the end of therapy measures were collected that this was a “bad week to do them”, due to a sudden dramatic change

	in her medication which had resulted in a worsening of mood and physical exhaustion. This is reflected in the session six CORE-5 score which is dramatically reduced.	
Feel more able to cope with everyday life	**Therapist process notes** Over the course of sessions, Claire was more able to start problem-solving without prompting from the therapist and spoke more optimistically about the future.	**Simplified-PQ scores** Claire's pre and end of therapy score pertaining to this specific problem did not change from pre-therapy to end of therapy (remained as 'very considerably' bothering her).
Feel less anxious	**Simplified-PQ scores** In response to this particular problem, Claire scored it as bothering her "very considerably" (6 out of 7) at pre-therapy, and 'considerably' (5 out of 7) at end of therapy, indicated some decrease.	**Therapist notes** Claire reported feeling anxious each week. **CORE-5 weekly scores[28]** Regarding the question pertaining to anxiety on the CORE-5, Claire's scores were variable and unstable:

[28] Multiplied by 10 as per author recommendations.

Therapist process notes

Although Claire reported feeling anxious each week, she also reported engaging with mindfulness techniques which provided some relief. Claire was hopeful that this would continue to improve her anxiety long-term with further practise.

Change interview

“I did find it useful, and even today when I was sat at hospital and I was really worrying and nervous, and because Sophie had like gone through about doing mindful activities… I sat doing them for like 5 minutes in the hospital, just to take my mind off it” (11-16)

Pre-therapy: Claire scored 30 out of 40

Session 1: Claire scored 30 out of 40

Session 2: Claire score 20 out of 40

Session 3: Claire scored 30 out of 40

Session 4: Claire scored 20 out of 40

Session 5: Claire scored 20 out of 40

Session 6: Claire scored 30 out of 40

Feel less guilty when I can't do things with the children.	**Simplified-PQ scores** With regards to this particular problem, Claire scored this as bothering her 'very considerably' (6 out of 7) pre-therapy, and this decreased to bothering her 'moderately' (4 out of 7) at end of therapy. **Change interview** **"**I just telling myself that it's okay how I'm feeling, it's okay to feel like that, and not to like beat myself up for the way that I feel" (23-25) **Therapist process notes** Session 4: Claire was able to identify that the children was happy even if they weren't constantly entertained or provided with an activity by Claire. She was also able to challenge thoughts that she wasn't doing	**Therapist process notes** In sessions one, two, and five, Claire spoke of feeling guilty when she was too busy or exhausted to engage in activities with the children.

	enough for people, and acknowledged the importance of creating time for herself.	
Overall score for PQ goals		**Simplified-PQ scores** Although improved, Claire's score remained within the clinical caseness range at end of therapy and did not change statistically significantly.
Reduction of global distress	**CORE-5 score** Claire's overall mean score improved statistically significantly from pre-therapy to end of therapy. **Therapist notes**	**CORE-5 score** Although this score changed statistically significantly, Claire remained within clinical caseness. **Therapist notes**

	It was clear from sessions that Claire became more able and willing to engage in difficult memories and feelings, and to discuss these, which was a large change for her.	It was not clear from Claire's presentation in sessions that she had experienced the changes she reported in the change interview and the psychometric data.

Table 19.

Is therapy (generally) the cause of the reported changes? (Or alternatively is any change due to client's attributes or events occurring outside of therapy?)

Supporting evidence (change is due to therapy)	**Refutational evidence (changes due to external factors)**
Change interview	**Therapist notes**
"Probably everything put together" (38) *[in response to the question asking about therapy, "was it more everything put together or was there one part"]* "Probably not, no, I've always been like it" (55) *[in response to the question "Do you think that's something that could have changed if you hadn't attended that therapy?"]*	Claire reported in sessions that she experienced fluctuations in her mood due to midwifery and consultant appointments regarding the gestational diabetes and consideration of whether she needed to be induced early. Claire also had her medication reduced dramatically between session 4 and 5 and said this had very negatively affected her mood and resulted in her feeling exhausted.

Attribution: Change not possible without therapy

"Not that I can think of" (86) *[in response to the question "Is there anything about any personal resources you have, so any strengths or previous experience that made it easier for you to do the therapy?"]*

*"*I developed gestational diabetes so had a lot of different appointments and things like happening with the baby and stuff so it has been quite stressful" (7-9) *[in response to interviewer suggestion that any worsening of distress was due to this]*

Attribution: lack of change due to external events

Attribution: Any positive fluctuations due to medication and lack of appointments

Therapist notes

In assessment, Claire spoke of having mood difficulties since her teenage years with little change in this over the years

(spanning approximately 15 years). Therefore, the changes Claire experienced which are also reflected in score changes, suggest that this was due to the therapy.	

Table 20.

What specific events or processes brought about the reported changes?

Target	**Supporting evidence**	**Refutational evidence** (proposes that any therapy would have enabled changes or intervention was hindering/ineffective)
Specific CFT techniques	**Change interview** *"…*all the different activities she did with me. I don't know, most of them I found really useful" (65-66) *Attribution: CFT-specific techniques*	**Change interview** "I think like just the way Sophie is, and she's a very like calming person" (64-65) *Attribution: Therapeutic relationship*

Specific CFT process: Increasing compassion	**Change interview** “Probably like talking about like when we did the compassion formulation thing and talking about things from the past and stuff like that was upsetting, but when I look back on it at the end, I could see things clearer” (116-118) *Attribution: CFT-specific processes: Increasing distress tolerance, sensitivity, empathy* **Therapist process notes** Session 1: When reviewing the formulation Claire had thought of a ‘key fear’ to add to it since the assessment session. Claire connected to the soothing breathing exercise and was able to compare this to other mindfulness exercises. Claire was openly emotional in the session which was encouraging.	**Therapist process notes** Session 2: When asked how big her contentment system would be if she were alone and not having to do anything for the children, Claire said it would be very small. When exploring a recent emotive event, Claire described a happy memory becoming tinged with guilt because her daughter noticed she looked “like she was about to cry.” Claire described setting a rule for herself that she shouldn’t show her children anything other than happiness. Claire described a ‘mental block’ trying to apply compassion towards herself. Session 4: Claire described persistent difficulties in exhibiting compassion towards a specific person in her life.

	Attribution: Increasing sensitivity and empathy. Session 2: Claire describes her ability to show compassion towards otherwise via volunteer work working with vulnerable people. *Attribution: Compassion towards others.* Session 3: Claire was able to insightfully reflect on any barriers to compassion by describing and exploring painful memories. *Attribution: Increasing distress tolerance and empathy.* Session 4: Claire purposely made time for herself to practise her techniques	**CEAS scores** Claire's 'compassion for self' action score, 'compassion from others' action score, and OAS score, all statistically significantly worsened pre-post therapy.

Attribution: Increasing care for well-being, compassion towards self.

Session 5: Claire completed the compassionate image between-sessions and had carefully thought about and connected to the image. Claire continued to share very painful memories. Claire was able to compassionately describe her formulation and challenge some of the initial thoughts she had about herself and others.

Attribution: Increasing compassionate image, distress tolerance, empathy.

CEAS scores

Claire's 'compassion from others' score statistically improved on many of the same weeks her CORE-5 score improved.

	Attribution: Increase in compassion leads to reduction in distress. Claire's 'compassion for self' and 'compassion from others' scores improved statistically significantly.	
Specific CFT process: Decreasing guilt and shame	**Change interview** "…just telling myself that it's okay how I'm feeling, it's okay to feel like that, and not to like beat myself up for the way that I feel" (24-25)	**Therapist process notes** Session 1: Claire spoke of guilt around becoming angry at her son even when appearing appropriate. Claire said she wasn't sure she would be able to attend each session due to feeling like she has to commit to various events and put everyone else's needs before her own. Session 3: Claire described feeling guilty that she may have done something to cause her baby's weight fluctuations, or may not have been appropriately

	managing her blood sugars, even when informed by health professionals this was not the case. **OAS score** Claire's OAS score remained in the clinical range from pre-therapy to end of therapy and statistically significantly worsened.

***Qualitative Information about helpful aspects*.** This data is described in Table 21 and refers to the formulation process as being particularly helpful for Claire.

Claire spoke quite generally about particularly helpful aspects and significant events. She referenced that it was helpful “just like talking with Sophie and like going through all the compassionate image stuff” and when prompted about particular aspects, she stated “probably everything put together.” However, Claire mentioned the therapeutic relationship and therapist approach on a number of occasions throughout the interview as something which was helpful. Claire referenced mindfulness in the change interview as something she found particularly helpful and gave the example of when she had implemented it recently in an anxiety-provoking situation.

Table 21.

Helpful aspects of therapy identified at post-treatment change interview

Change and participant narrative	**How helpful was this aspect on a scale from 1 to 9?** (where 1 is extremely unhelpful and 9 is extremely helpful)	**If the participant thought this change would have occurred without therapy**
1) Non-judgemental towards self about feelings "…just telling myself that it's okay how I'm feeling, it's okay to feel like that, and not to like beat myself up for the way that I feel"	[not asked in interview]	"Probably not, no, I've always been like it"
2) The therapist's calming voice "…it's like different to when Sophie does it, cause it's like Sophie's got a nice calm voice and I found it harder with YouTube videos with somebody you didn't know and stuff"	8	[not asked in interview]

3) Practising compassionate skills in session "Sophie had like gone through about doing mindful activities and just do this to take my mind off what I'm worrying about for 5 minutes" "…going through all the compassionate image stuff" "…everything put together" "…all the different activities she did with me"	7	[not asked in interview]

Arguments for Claire's case. The arguments below summarise and are assisted by Figures 6-8 and Tables 19-21, which provide evidence for and against change occurring, attribution to therapy, and the relevance of any specific events occurring within or outside of therapy.

Affirmative case. Any relevant factors for Claire will be explored below in further detail.

Changes across therapy. Three measures demonstrated statistically significant improvements from pre-therapy to end of therapy. Claire also spoke positively in the CI of changes she had experienced throughout therapy. Although the total mean score for the PQ did not change statistically significantly, the item pertaining to Claire's problem of "feeling guilty that children off school but feel unable to do things" did change statistically significantly.

Retrospective attribution. Claire attributed changes only to therapy and attributed any existing or fluctuating distress to external factors. When completing measures in sessions, Claire said that she felt her anxiety peaked when she had attended or anticipated a hospital appointment or found out worrying information about her health and the baby's health.

When the end of therapy measures were completed in session five, Claire stated that she felt it was a "bad week" to complete them as her medication had been dramatically decreased in the preceding week, and therefore she felt that particular week was not representative of the improvements she had noticed. This was an important consideration and was reflected in her session six scores which all improved from session five.

Therapist attributed these changes to the therapy. Claire reported each week that a combination of compassion and mindfulness techniques had been helpful between-sessions, and that any fluctuations in distress were likely due to hormones, medication, or anxiety-inducing hospital appointments.

Process-outcome mapping. Claire did not specify particular techniques or sessions which were particularly helpful or responsible for change, instead describing a combination of techniques and practice. However, her 'compassion

from others' action score statistically improved on many weeks her CORE-5 score statistically improved.

Change in stable problems. Baseline scores could not be obtained, but in the assessment session Claire described her difficulties as having occurred for over 15 years, with no improvement. Claire reported in sessions that this was the first time she had experienced improvement in her mood and considered this to be a stable improvement as previous mood improvements had been temporary, lasting only days.

Event-shift sequences. Claire's compassion scores sometimes increased during times of distress, and her shame scores decreased during these times, which may indicate that she was able to use the CFT techniques in the way she related to herself and others during these distressing times. This is particularly pertinent for Claire as she said in sessions and within the CFT formulation that a safety behaviour of hers was to avoid asking others for help and to prove to herself that she could cope on her own if her partner left.

Psychobiological factors. Although Claire's distress peaked and troughed throughout the intervention, she attributed this to hospital appointments and the anxiety arising from her gestational diabetes, as the appointments discussed the baby's (fluctuating) weight and Claire's blood sugar levels. According to Claire, the gestational diabetes made it more difficult for her to keep her mind on things when engaging in mindfulness and compassion exercises.

Statistical artefacts. In addition to potential statistical errors, Claire commented that some of the wording in the questionnaires was confusing, particularly where negatively worded questions were used in the CEAS, which may have resulted in inaccuracy in capturing her experiences, and may explain why significant change was absent in some measures, including initial clinical caseness.

Conclusion. This affirmative case stipulates that:

- Claire demonstrated substantial change in her problems.

- Claire attributed these changes to therapy, even if her scores did not immediately correspond with significant sessions.
- The therapist attributed most of these changes to therapy.
- This evidence contradicts sceptic non-therapy reasons for change and/or lack of change.

This evidence provides a basis for you to:

1. Support the case that Claire changed substantially during the period of therapy; and

2. Draw the inference that this change was caused by Claire's participation in the CFT intervention.

Sceptic Case. The sceptic case describes a good faith attempt to counter the argument that Claire changed substantially during therapy or that this change was due to the CFT intervention. In order to do this, the sceptic case systematically examines the client's case record for evidence of alternative explanations, as suggested by Elliott (2002). Any relevant pieces of evidence for Claire will be explored below.

*Trivial or negative changes on measurement***.** Claire's scores on the PQ, OAS, and CORE-5, remained within clinical caseness from pre-therapy to end of therapy, despite any statistically significant changes. Claire's 'compassion for self' action score, 'compassion from others' action score, and OAS score significantly worsened pre-post therapy.

Statistical artefacts. The presence of a statistically significant change in PQ scores could be due to statistical inaccuracy. Additionally, it could be possible that Claire misinterpreted the wording of questions in the PQ or completed the measure in a way which inflated apparent improvement. RC min and clinical caseness scores were crude calculations for all measures except the PQ, based on little existing research using these measures. Therefore, all scores have been examined even though it may not have appeared that Claire was within clinical caseness pre-therapy. The sceptic case suggests that type I errors could have been responsible for any changes.

Relational artefacts. Claire reported in the change interview that the therapist's voice and approach was helpful, which may indicate a positive therapeutic relationship and therefore a higher chance of reporting increased change due to a desire to preserve this relationship or avoid offending the therapist.

Expectancy artefacts. In response to the question, "at this point, how much do you really *feel* that the sessions will help you to manage your difficulties?" Claire scored 5 out of 7, indicating 'considerably.' This indicated a relatively high expectation for therapy helping her, which may have resulted in a more positive report of symptoms. However, Claire stated each session she could not remember how she had rated each measure the week before, which may suggest that she was not intentionally increasing score ratings each week, alongside the fact that Claire's scores often fluctuated.

The following explanations as suggested by Elliott (2002) stipulate that change has occurred but not due to therapy and is therefore due to the following factors: 5) self-correction, 6) life events, 7) psychobiological factors, and 8) reactive effects of research participation.

*Self-correction and other factors***.** Claire described feeling less anxious as her due date approached because she was anticipating relief in knowing her baby was safely born. Therefore, the simple passing of time may have contributed to an improvement in distress and increased her capacity to demonstrate compassion, rather than the therapy itself being responsible for this. Although Claire's scores did not steadily improve over time, she reported external events as negatively affecting her mood, which may explain why her overall scores improved and that this was due to anticipation of relief.

Psychobiological factors. Although not reported by Claire, changes in hormones may have contributed to positive fluctuations in mood, distress, or compassion, particularly as hormones likely increase as the birth date approaches in preparation for attachment with the baby. Attachment is strongly connected to feelings of contentment and compassion, so may explain

improvements in these areas. Additionally, changes in hormones, medication, and anxiety-inducing events caused a worsening of distress, and therefore an absence of these factors may have created a comparative improvement, rather than improvement due to therapy-specific factors.

*Reactive effects of research participation***.** Although in the change interview Claire reported having been unaffected by participating in research, there may have been less obvious participant bias and social desirability occurring, particularly as Claire was aware when consenting to participation that she would be meeting with a researcher to discuss her experiences.

Improvements not maintained despite life stressors. Claire spoke of external factors negatively affecting her mood, yet it would be hoped that a successful therapeutic intervention would protect against life stressors and physical fluctuations. However, this did not seemingly occur when examining weekly scores. Follow-up data had not yet been collected at the judicial stage to assess whether incubation effects existed.

*Lack of event-shift sequences***.** Although half of Claire's scores improved from pre-therapy to end of therapy, when considering fluctuations in scores on a weekly basis, decreases in distress did not always correspond with increases in compassion. Therefore, although there may be a relationship between these two factors when considering pre and post scores, a causal relationship alongside direction of causation cannot be stipulated. Increases in compassion and decreases in shame may instead be due to Claire's decreases in distress which could be due to other factors which were unnoticed.

Conclusion*.* This sceptic case stipulates that:

- Claire did not make significant improved changes.
- Claire did not attribute these changes to therapy.
- Any minor changes made were due to extra-therapeutic factors.
- This evidence contradicts evidence presented by the affirmative case.

This evidence provides a basis for you to:

1. Reject the case that Claire changed substantially during the period of therapy; and
2. Draw the inference that any change was caused by extra-therapeutic factors.

3.1.3 Ruby's rich case summary

Further contextual information. Ruby had completed two undergraduate degrees at university and was working in a managerial position full-time prior to maternity leave. The pregnancy was not considered high risk although Ruby had started experiencing pelvic pain prior to and throughout the intervention. PTSD triggers for Ruby included attending midwifery and consultant appointments, discussion around the birth, other people's birth stories, and people commenting on her pregnancy or the size of her abdomen. Ruby was not aware of any other pregnancies which had occurred aside from her two children (including her unborn child). Alongside the PTSD, Ruby had also been diagnosed with an anxiety disorder. The SCP had recommended that Ruby engage with trauma-focussed work to address the PTSD, but Ruby had felt too overwhelmed at that time. The pregnancy was planned and both Ruby and her husband were very excited, but Ruby was understandably anxious about the birth and any conversations surrounding this or the pregnancy generally. Although Ruby reported that her husband and family were supportive and she had a large group of friends she saw regularly, she did not feel able to share her feelings about the pregnancy and birth with her friends or family, although her husband was aware of these difficulties. Ruby reported that her CPN from the perinatal service and specialist midwife were helpful.

Ruby said she found it very reassuring and a huge relief that discussion about the trauma was not required for CFT. Ruby was informed that 'present fears' within the formulation did not need to relate to the trauma she had experienced and that the focus could be on generalised anxiety and distress. However, Ruby also chose to report thoughts and fears which pertained to the traumatic

experience. It was very important that Ruby felt in control of the conversation, so no questions were asked regarding the traumatic event.

Adaptations to the CFT protocol. Ruby stated that she only felt able to access the CFT intervention if she did not need to discuss the trauma or her PTSD symptoms. The CFT formulation was subsequently adapted so that 'early experiences' were removed, and the focus was solely on generalised present fears.

Client and therapy goals. Using the Personal Questionnaire, Ruby generated her personal goals for therapy which were as follows:

1. Feel less worried about the birth plan and baby.
2. Feel more able to trust professionals and feel in control of the birth plan.
3. Feel less guilty.
4. Improve concentration and attention.
5. Feel less anxious on a daily basis.

The goals for CFT across all clients are as follows:

6.) Increase compassion towards self, towards others, and allow from others (measured using the Compassionate Engagement and Action Scales).
7.) Reduce feelings of guilt, shame, and self-criticising (measured using the Other As Shamer scale).

Additionally, as the goals for the therapy intervention were to reduce distress, this was measured weekly using the CORE-5 (assessing global functioning, including mood and interpersonal relationships).

Table 22 presents data both for and against each of these goals being met throughout the therapeutic intervention, with regards to the research question "has meaningful change occurred?"

Quantitative outcome measures. Ruby's weekly measures are represented as line graphs in Figures 9 and 10.

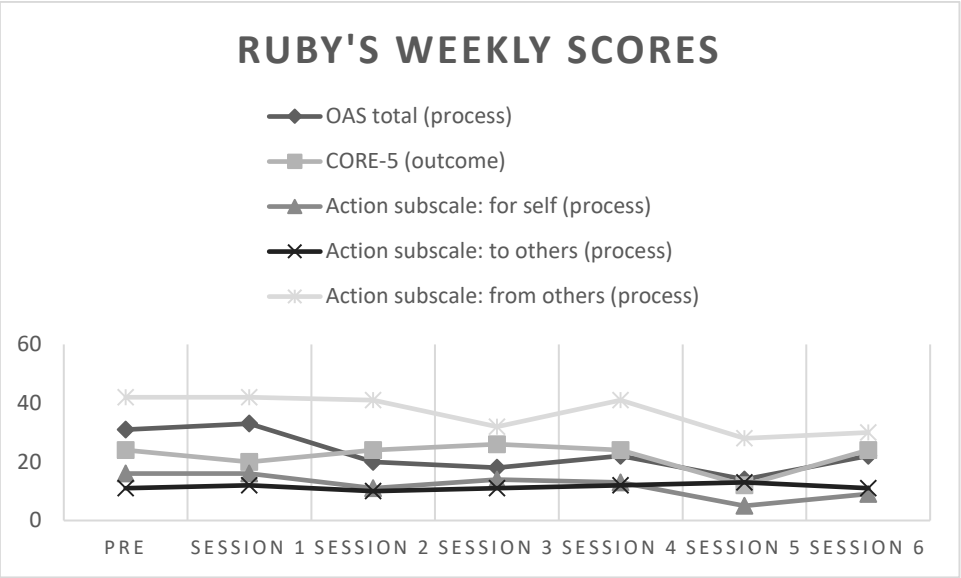

Figure 9. All weekly measure scores

Note. Higher scores indicate higher distress, higher shame, and less compassion. CEAS scores have been reversed for purpose of graph, and CORE-5 mean scores have been multiplied by 10 to enable ease of comparison with other measures.

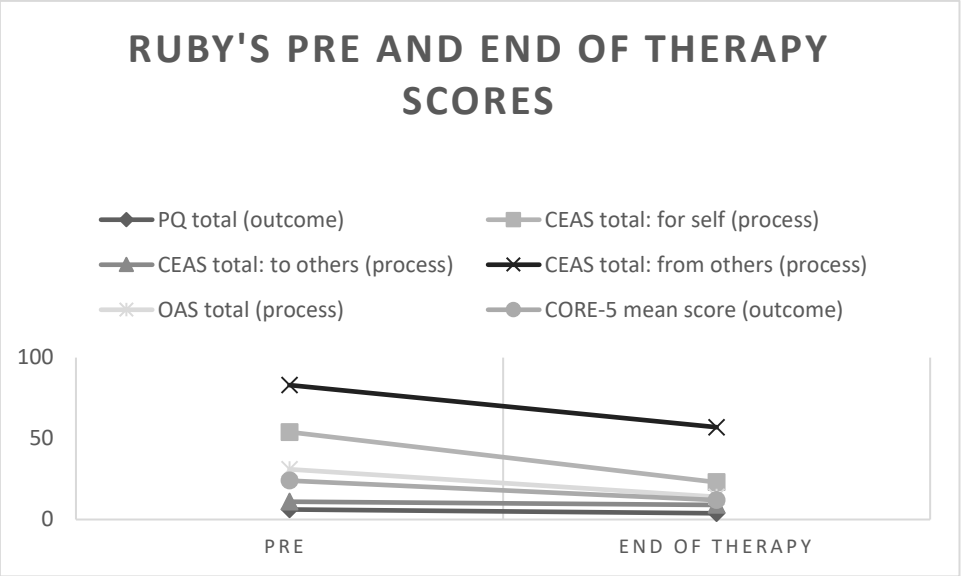

Figure 10. Ruby's pre and end of therapy scores

Note. Higher scores indicate higher distress. CEAS scores have been reversed for purpose of graph, and CORE-5 mean scores have been multiplied by 10 for ease of comparisons against other measures.

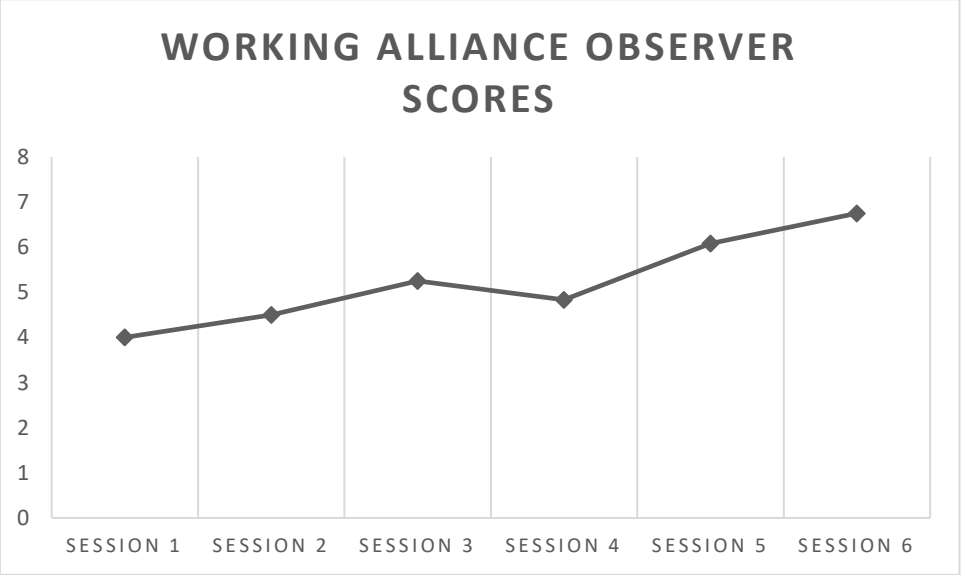

Figure 11. Working Alliance Inventory – Observer scores

Note. Higher scores indicate greater working alliance between therapist and client

Qualitative outcome assessment. Using the PQ, Ruby reported specific difficulties which were bothering her at that time, and specified how much each of these problems had been bothering her over the past week. At pre-treatment Ruby rated 'worry about the birth plan and baby' as bothering her the maximum possible, felt that 'loss of control and trust' bothered her 'very considerably', 'feeling guilty' bothered her 'very considerably,' 'difficulties with concentration and attention' bothered her 'considerably' and anxiety bothered her the maximum possible.

Towards the end of therapy, Ruby rated 'worry about the birth plan and baby' as bothering her the maximum possible (no change). Regarding 'loss of control and trust' Ruby stated that this had bothered her 'considerably' over the past week (an improvement), and that 'feeling guilty' had also bothered her 'considerably' (an improvement). Ruby rated 'difficulties with concentration and attention' as bothering her 'very little' (a large improvement), and that anxiety had bothered her 'moderately' (a large improvement).

At the change interview, Ruby was asked to describe any changes she had noted in herself over the intervention, which are presented in Table 22. Regarding any changes she noticed, Ruby was asked to consider whether she expected the change, how important that aspect was for her over the course of therapy, and how likely she felt the change would have been without the therapeutic intervention.

***Client and therapy goals*.** Using the Personal Questionnaire, Ruby generated her personal goals for therapy which were as follows:

1.) Feel less worried about the birth plan and baby.

2.) Feel more able to trust professionals and feel in control of the birth plan.

3.) Feel less guilty.

4.) Improve concentration and attention.

5.) Feel less anxious on a daily basis.

The goals for CFT across all clients are as follows:

8.) Increase compassion towards self, towards others, and allow from others (measured using the Compassionate Engagement and Action Scales).
9.) Reduce feelings of guilt, shame, and self-criticising (measured using the Other As Shamer scale).

Table 22 presents data both for and against each of these goals being met throughout the therapeutic intervention, with regards to the research question "has meaningful change occurred?"

***Evidence for and against CFT-specific processes*.** Table 23 presents evidence for and against whether therapy was the cause of change, in response to the research question, "is therapy (generally) the cause of the reported changes?" This table also presents evidence in favour of the alternative argument, that any change is due to client's attributes or events occurring outside of therapy.

Table 24 presents evidence for and against change pertaining to the research question, "what specific events or processes brought about the reported changes?" This table highlights whether the participant reported specific CFT techniques or processes in assisting or hindering therapeutic change. It also presents evidence for and against changes in CFT-specific targeted processes: increases in compassion and decrease in guilt and shame. The refutational evidence proposes that any therapy would have enabled changes, or the CFT intervention was hindering or ineffective.

Attributions have been suggested by the first author where appropriate, to assist with understanding and context.

Table 22.
Has meaningful change occurred?

Therapeutic goals	**Supporting evidence**	**Refutational evidence** (meaningful change did not occur)
Change generally	**Change interview** **"**By session 5 and 6 I felt I was really making some good progress. Able to use the imagery and breathing techniques, and things like that helped me week to week with things that I'd experienced that week." (9-11) "I just feel like I've got better." (59) "…realised that I have actually got a lot out of it, and I got a lot more than I expected to." (87-88)	**Simplified-PQ post-therapy evaluation** Ruby scored 5 out of 7, indicating 'considerably' regarding how much the therapy helped her. However, she reported in the change interview that she did not feel anything was missing or that change had not occurred in areas where she was expecting it to, yet this score did not indicate it had helped the maximum possible.

Simplified-PQ post-therapy evaluation

In response to the question, “at this point, how much do you really *feel* that the sessions helped you to manage your difficulties?” Ruby scored 5 out of 7, indicating ‘considerably.’ This indicates positive self-reported change.

Therapist notes

Although Ruby had stated she did not want to discuss the trauma at all and did not feel able to undergo trauma-focussed work prior to the CFT intervention, she spoke about the trauma (unprompted) during the sessions, including nightmares, thoughts, and feelings around this.

	Session 3: Feedback was received from the perinatal team that positive changes in Ruby had been noticed by staff, and that Ruby reported noticed changes herself. Changes were noticed in Ruby across the sessions whereby she presented as more relaxed, able to challenge her own thoughts and behaviour, and was positive about the future and her ability to cope.	
Worry about birth plan and baby	**Therapist process notes** Session 5: Ruby said she had managed to attend a midwifery appointment to discuss her birth plan, which is something she had previously avoided due to it being one of her strongest trauma triggers. Ruby reported that she managed	**Simplified-PQ pre and post measure** The item pertaining to this specific goal did not change from pre-therapy to end of therapy, and the score remained the maximum possible.

	to attend this appointment using the skills taught in sessions and felt “much better” and “positive” about the birth plan. Session 4: Ruby reported utilising CFT techniques to significantly reduce her anxiety prior to appointments discussing the birth plan and pregnancy.	**Therapist process notes** Although she managed to attend appointments and respond to these differently, Ruby was still affected by worry and anxiety prior to these appointments.
Loss of control and trust	**Simplified-PQ pre and post measure** Reduction in PQ ratings of this problem Pre-therapy: score of 6 End of therapy: score of 5 **Therapist process notes**	**Therapist notes** Prior to midwifery and consultant appointments, Ruby said these feelings arose in her and resulted in the anxiety she experienced. This did not seem to change until the birth plan appointment she attended, following which her anxiety hugely reduced.

	Session 5: Ruby said she had managed to attend a midwifery appointment to discuss her birth plan, which is something she had previously avoided due to it being one of her strongest trauma triggers.	
Feeling guilty	**Simplified-PQ pre and post measure** Reduction in PQ ratings of this problem Pre-therapy: score of 6 End of therapy: score of 5 *Please see Table 23.*	*Please see Table 23.*
Difficulties with	**Simplified-PQ pre and post measure** Statistically significant reduction in PQ ratings of this problem	**Therapist notes** Ruby did not verbalise any improvements in this throughout therapy.

concentration and attention	Pre-therapy: score of 4 End of therapy: score of 1 **Therapist notes** Ruby did not appear to have difficulty with concentration and attention during therapy sessions and was able to engage in within-session practise. She found the mindfulness techniques particularly helpful and practised these between-session.	
Anxiety	**Simplified-PQ pre and post measure** Reduction in PQ ratings of this problem	**CORE-5 weekly scores[29]** No sustained improvement regarding the item pertaining to anxiety.

[29] Multiplied by 10 as per author's recommendations

	Pre-therapy: score of 7 (maximum possible) End of therapy: score of 4 **Therapist notes** Ruby consistently reported from session one that practising mindfulness between sessions significantly improved her anxiety. She was able to observe her anxious thoughts during the 'leaves on a stream' exercise in session 5.	Session 1: Score of 20 out of 40 Session 2: Score of 20 out of 40 Session 3: Score of 30 out of 40 Session 4: Score of 30 out of 40 Session 5: Score of 10 out of 40 Session 6: Score of 20 out of 40
Overall score for PQ goals	**Simplified-PQ pre-therapy expectation** Ruby's overall score from pre-therapy to end of therapy changed significantly, according to the reliable change minimum. At three-month follow-up, this score continued to improve statistically	**Simplified-PQ pre and end of therapy** Although significantly reduced, Ruby's score remained within the clinical caseness range at end of therapy.

significantly and took her out of clinical caseness.

Simplified-PQ end of therapy evaluation

In response to the question, “at this point, how much do you really *feel* that the sessions will help you to manage your difficulties?” Ruby scored 4 out of 7, indicating ‘moderately.’ At the end of therapy, her post-therapy evaluation indicated that she felt the sessions had helped her manage these difficulties “considerably.” This suggests the sessions helped her more than she had expected.

Reduction of global distress	**CORE-5 weekly measure** Ruby's total score changed significantly from pre-therapy to end of therapy. At three-month follow up, this continued to improve statistically significantly, and also took her out of clinical caseness. **Therapist notes** Session 6: Ruby said that once the baby was born, she was very hopeful and optimistic that she would feel "back to normal again."	**CORE-5 weekly measure** Ruby's score remained within clinical caseness from pre-therapy to end of therapy.

Table 23.

Is therapy the cause of the reported changes? (Or alternatively is any change due to client's attributes or events occurring outside of therapy?)

Supporting evidence	**Refutational evidence** (changes due to external factors)
Change interview	**Therapist notes**
"I really kind of like felt that I was able to take what I'd already learned from the sessions on board and put those into practise a little bit more" (7-9) *Attribution: CFT-techniques and discussion from within sessions* "I really feel like I've learned something…" (95-96) *Attribution: Learning from sessions* "No, no. They're not something I could have just done out on my own. No, definitely not" (102-103) *[in response to a*	Assessment: Ruby said she had been practising relaxation techniques with her CPN from the perinatal team. *Attribution: Relaxation techniques outside of intervention* Session 5: Ruby reported she felt much less anxious about the birth and birth plan after attending a midwifery appointment to discuss this. Ruby also reported finding something incredibly helpful and profound that her midwife had said when discussing the birth plan. *Attribution: Reduced anxiety due to midwife*

question asking whether changes could have occurred without therapy]

Attribution: Client attributes changes to therapy

"Cause obviously I suppose it works better when you really took the time to do the exercises more in-between the sessions. And I suppose sometimes I didn't quite do enough, you know if something had happened or I'd been busy with work, school, things like that. So, there were a couple of weeks where sometimes I just feel like I didn't have enough time." (140-144)

Attribution: Any scarcity of change due to Ruby's lack of opportunity to practise techniques

"…when I've had either my consultant or doctor or things gone on like that, they've thrown my mood and feelings and

Session 6: Ruby said that once the baby was born, she was very hopeful and optimistic that she would feel "back to normal again."

Attribution: Birth rather than intervention

my mental health really, they throw it completely off…" (159-162)

"It still helped but I've had so much anxiety around other things that I feel like this could never have fully helped. The other stuff was just too big." (166-168)

Attribution: Any scarcity of change/worsening scores due to external factors

"It's something that I'm gonna keep practising and you know, I've got something that will hopefully continue to benefit me. I know where I'm going really." (252-253)

Attribution: CFT-specific techniques

Table 24.

What specific events or processes brought about the reported changes?

Target	**Supporting evidence**	**Refutational evidence** (proposes that any therapy would have enabled changes or intervention was hindering/ineffective)
Specific CFT techniques	**Change interview** "I suppose it made me think that I do need to try and do something to think a little bit differently" (18-19) [referencing drawing the Affect Regulation Systems] "It was that drawing of the circles which really made me think oh I don't like that, I don't like what I've written so I want to try and make this better, like that really worked." (22-24)	**Change interview** **"…**maybe I could take a bit more control instead of just letting myself feel a certain way…" (41-42) *Attribution: Increasing insight and empowerment through therapy* "I really liked the body scan, I really enjoyed that. I found that really relaxing, and that was really good…" (47-48) *Attribution: Mindfulness exercise (integral to CFT but also other therapies)*

“It made me realise things I hadn’t realised before” (29-30)

Attribution: Specific CFT technique

“All the resource sheets were really helpful for me” (20) *Attribution: CFT-specific handouts*

“running over the other things like the body scans as well, and the old brain new brain and things like that, and which wolf you’re gonna feed and which teacher you’re gonna be. And it kind of made it all a bit more…not that it made it a bit more sense but it felt more applicable to do something about” (34-37)

Attribution: Specific CFT techniques

“…what really helped was, can’t remember which session it was, the one where we talked about kind of like talking about someone else… if someone was in my situation, the same situation as me, what would I say to them? And then thinking about it like that was much more easier for me” (64-68)

Attribution: CBT thought-challenging technique

“I never found myself not wanting to go, which is something I sometimes do feel and doesn’t make me feel very confident. But I was always quite comfortable and quite happy to go to the sessions. So yeah it was really good.” (96-98)

Attribution: Potential combination of factors not necessarily specific to CFT

	*"…*we talked about the head and the heart. And kind of like the head thinks about what you would say, but you feel like it's actually hard to almost believe it." (70-72) *Attribution: Specific CFT technique*	"I think it was Sophie as a person, she's always really professional and I felt I got on with her well. She's obviously really like welcoming and she's always really organised and everything's always ready, and she's always the same. Like she's always calm and smiling, and I never felt judged by her or anything like that." (108-111)
	"…what I liked about this thing the most is that I actually enjoyed it. And I can't say that about all the past things I've done..." (92-93) *Attribution: Enjoying CFT specifically*	"Another thing that I liked was that if I'd mentioned something or we had previously talked about my family or something personal to me, Sophie remembered that…" (123-125)
	"I don't know what I brought to be honest. I'm not sure. I feel like I took more than I gave. I'm not sure what I gave." (135-136) *Attribution: Change not due to client attributes*	"…it just felt like she had the time and she was listening to me, and I didn't feel rushed or anything like that. So it made it feel a lot more personal for me." (130-132) *Attribution: Therapist attributes*

"…a tool in my pocket that I was able to use…I could look back and re-read the previous session or whatever, just to remind myself. I found the resources really useful and the handout sheets." (181-185)

Attribute: Handouts detailing specific CFT techniques

Working alliance scores

The fluctuations in working alliance scores did not correspond with consistent subsequent changes in Ruby's scores.

Attribution: Not due to relational artefacts

"There were things I didn't really want to talk about, but she never did ask me anything that I was uncomfortable with, which I appreciated." (113-115)

Attribution: Respecting boundaries regarding questions

"I felt like I had a little bit of an insight before I actually went to the first one. So I think if I'd had no contact it would have felt more daunting for me, but that's helped." (233-235)

"…I just think that it did make a big difference, how she made me feel and with those questions." (115-116)

Attribution: Working alliance

	"I always tried to be really honest and open, and kind of tell her exactly how I felt or what my view was on what she said or how I felt." (122-123) *Attribution: Client attributes*
	"I also felt the motivation because it was weekly, I felt like it was probably better than any greater length of time like fortnightly or monthly. I think it did keep me quite focused…" (147-149) *Attribution: Weekly therapy sessions*
	"…just having something to take away, that was good for me." (180) *Attribution: Client handouts*
	"just having a piece of paper to hold sometimes, it made me feel more comfortable…it gave me something to

have in my hands or something to do with my hands, because I'm quite fidgety…" (190-193)

Attribution: Handouts useful in terms of a comforting material object

"cause obviously most appointments you go to them and then they're like making the appointment for the next week or whatever. It was good for me that she did the whole lot in one go so I knew where I was and I could sort out childcare and things like that. So that was good, I liked that." (238-242)

"She obviously came as close to my house as possible and I liked that, cause it can be a bit of pain going further and it was really local. She came on time and like I say, the room was always set up and things like that…" (242-245)

Attribution: Practical considerations

"I would definitely recommend therapy…" (261)

Attribution: Attending therapy generally

Working alliance scores

These scores generally increased over the course of therapy so changes over time have been due to strengthening of the therapeutic relationship.

There was a worsening of the therapeutic relationship in session 4, and when measures were completed following this session, all of Ruby's scores worsened apart from the 'compassionate action towards others' score. If the CFT intervention itself was responsible for change, the therapeutic relationship would not have affected these scores.

Specific CFT process:	**Change interview**	**Therapist process notes**
Increasing compassion	"I suppose it made me think that I do need to try and do something to think a little bit differently" (18-19) [referencing drawing the Affect Regulation Systems]	Session 1: When drawing her Affect Regulation Systems, Ruby drew her affiliative-focused/compassion system as very tiny.
	"It was that drawing of the circles which really made me think oh I don't like that, I don't like what I've written so I want to try and make this better, like that really worked." (22-24)	Session 2: Although able to connect with compassion towards other people, Ruby said she found it incredibly difficult to consider being compassionate towards herself.
	Attribution: Increasing care for wellbeing and insight	Session 4: Ruby reported finding it very difficult to imagine her 'compassionate-self image' and being self-compassionate.
	"…the old brain new brain and things like that, and which wolf you're gonna feed and which teacher you're gonna be." (34-36)	Session 5: When practising the 'compassion flowing out' exercise, Ruby found it very difficult to extend compassion to people she has had conflict with.

Attribution: Increasing compassionate behaviour, care for wellbeing

Therapist process notes

Session 1: Ruby engaged fully with the formulation process and was very reflective in exploring the different aspects. She appeared to connect to the concept of understandable reactions to situations and coping as best possible at that time, even if unintended consequences occur. Ruby found the soothing breathing exercise helpful and noticed physical and mental changes which occurred.

Session 2: Although she drew the contentment/compassion system as very tiny, Ruby exhibited great insight and reflection into

CEAS scores

There was not a statistically significant improvement in Anna's total score for 'compassion to others.'

Working alliance scores

During the session when the affect regulation systems were explored, there was an improvement in the therapeutic relationship, which may have been responsible for appraising this session as particularly helpful.

this, and said it motivated her to do something differently.

Ruby spoke compassionately and insightfully about the fact she is unable to engage in as many physical activities due to the stage of pregnancy and accompanying physical difficulties.

Ruby was able to think of lots of examples where she engages with and acts compassionately towards others. It was noticed that Ruby used CFT language when explaining how she felt and describing events which had occurred.

Session 3: Ruby reported practising the soothing breathing exercise multiple times between sessions and experiencing huge benefit from it. She said she never realised she could even 'breathe from her belly' and it is really helping her to relax.

Session 4: Ruby had chosen to engage in her own additional CFT technique between-sessions to overcome anxiety and distress she was experiencing prior to a midwifery appointment. She found huge benefit from utilising the ‘compassionate self’ concept.

Session 5: When reviewing the compassionate image homework, Ruby had managed to connect with this and put something for every aspect of the image. When practising the ‘leaves on a stream’ handout, Ruby had been able to practise separating herself from the thoughts and emotions she was experiencing. Ruby was also able to describe her formulation in a compassionate way.

	Session 6: When planning future goals, Ruby was enthusiastic in continuing to practise the techniques as she had found great benefit from them and felt she could continue this progress. **CEAS scores** Ruby's total score for 'compassion from others' and total and action scores for 'compassion for self' significantly improved from pre-therapy to end of therapy.	
Specific CFT process: Decreasing guilt and shame	**Therapist process notes** Session 4: Ruby said she expected her scores to worsen this week due to an anxiety-provoking consultant appointment she attended a few days prior to the appointment. Although Ruby reported feeling shamed, this appeared appropriate given the way she described the consultant responding to her.	**Therapist process notes** Session 3: When discussing the 'two teachers' metaphor, Ruby said she still had some resistance to it because she felt it was important to be firm, assertive, and disciplined. Ruby described feeling guilty or selfish to be compassionate towards herself and meet her own needs.

OAS score Ruby's perceived shame from others score (OAS) statistically significantly improved from pre-therapy to end of therapy. Ruby was also considered to be within the clinical caseness range at pre-therapy, but was outside of clinical caseness at end of therapy.	Session 4: Ruby reported high levels of shame pertaining to a consultant appointment she attended. Session 5: Ruby expressed guilt and shame over being unable to do physical activities and chores, due to stage of pregnancy and physical health difficulties. Ruby reported ruminating over an incidence where she potentially upset somebody, and feeling very guilty about this.

***Qualitative Information about helpful aspects*.** This data is described in Table 25.

Other factors deemed important in the therapy by Ruby in the change interview which were not explored in more detail, included the importance of feeling in control regarding the therapist avoiding asking any questions regarding the trauma, and the therapist's calm demeanour. Ruby also referenced that it was helpful that the therapist was organised, on time, and predictable in terms of the fact she did not seem to be shaken by anything and always acted professionally. Ruby also stated that she felt having weekly sessions were important as it gave enough time for practice, but also prompted her to stay focussed. Ruby also spoke of the usefulness of a combination of techniques, including the body scan, psychoeducation, and drawing the affect regulation systems.

Table 25.

Helpful aspects of therapy identified at post-treatment change interview

Change and participant narrative	**Why participant felt it was important**	**How important was this aspect?** (on a scale where 1 is 'extremely unhelpful' and 9 is 'extremely helpful')
1) The worksheets "…being able to take stuff away made me feel quite comfortable. I don't know, just having something to take away, that was good for me. I felt like I had something, like a tool in my pocket that I was able to use, and I found that quite comforting really to be able to take that away and have that with me throughout my week so I could look back and re-read the previous session or whatever, just to remind myself. I found the resources really useful and the handout sheets." (179-185)	"Because for me, I'm quite visual and it really helps. And sometimes even for me when I was reading them mid-session or whatever, or just having a piece of paper to hold sometimes, it made me feel more comfortable. I don't know if that's because I like to read and I'm visual or if it gave me something to have in my hands or something to do with my hands, because I'm quite fidgety in that way…having it literally there in front of me was something to take it away and definitely made it a lot more comfortable for me." (189-196)	9

***Arguments for Ruby's case*.** The arguments below summarise and are assisted by Figures 9-11 and Tables 22-25, which provide evidence for and against change occurring, attribution to therapy, and the relevance of any specific events occurring within or outside of therapy.

Affirmative case. Any relevant factors for Ruby will be explored below in further detail.

Changes across therapy. The affirmative case first requires that there has been a substantial change in Ruby's problems. In the CI when asked if Ruby had experienced any negative effects from the intervention, she stated that, "I just feel like I've got better." She then explained all the changes she had noticed from the therapy and the impact this had on her. In the change interview, Ruby reported that she sometimes did not have enough time to practise the techniques, and said she felt it would have been even more effective if this was possible. Therefore, Ruby appeared to attribute any lack of change to her inability to practise as much as she wanted to between sessions. Ruby's scores statistically improved in six out of nine measures pre-post therapy.

Retrospective attribution. In session five Ruby said she had managed to attend a midwifery appointment to discuss her birth plan, which is something she had previously avoided due to it being one of her strongest trauma triggers. However, Ruby reported that she managed to attend this appointment using the skills taught in sessions and felt "much better" and "positive" about the birth plan, which she was excited to discuss as she acknowledged this was a huge challenge and achievement for her. Similarly, although Ruby's score pertaining to the item 'worry about birth plan and baby' (on PQ measure) remained the same from pre-therapy to end of therapy, Ruby stated when completing this that it would have improved had it not have been for the constant worry she had experienced that week due to the upcoming midwifery appointment.

When asked whether Ruby felt the changes would have occurred on their own without therapy, Ruby was firm in her response stating that the changes would definitely not have happened if she had attempted this on her own. Ruby also

stated in the change interview that she did not feel she was personally responsible for changes which occurred and described, “I took more than I gave.” This implies that Ruby attributed all change to therapy rather than to her personal attributes.

Therapist attributed these changes to the therapy. After speaking to the perinatal team during participant recruitment assessment about her experiences, it was questionable whether a CFT intervention would be helpful for her and the team were concerned about overwhelming her. However, Ruby seemed to respond very positively to the therapy, and was able to make changes quickly and efficiently into her daily life.

Process-outcome mapping. When completing the measures at the beginning of session four, Ruby stated that she expected her scores to be worse that week due to anxiety-provoking appointments over the preceding days. Ruby’s score for ‘compassion from others’ action subscale statistically worsened. This would make sense according to Ruby’s experiences as she found the consultant and midwifery appointments triggered feeling out of control and mistrustful of others, as identified in her formulation.

In the change interview, Ruby said she felt that “everything clicked” around session four, and this may explain why her scores for ‘compassion for self’ action and CORE-5 score statistically improved at the beginning of session five.

Upon completing the end of therapy measures in session five, Ruby stated that she had experienced an anxiety-provoking week due to midwifery and consultant appointments, and that her scores were subsequently represented as more severe than they actually were on a weekly basis towards the end of therapy. Despite this, two measure scores significantly improved. However, most scores then somewhat improved in the final session, supporting Ruby’s statement.

Early change in stable problems. Baseline scores could not be obtained, but in the assessment session Ruby described her difficulties as having occurred for over approximately ten years with little improvement, despite

previous psychiatric and psychological intervention. Prior to the CFT intervention Ruby felt unable to discuss the trauma in any detail with the SCP, however over the course of therapy she started discussing it and exploring her thoughts and reactions to this experience, including requesting some psychoeducation around trauma and the impact of this.

Changes maintained despite life stressors. Interestingly, although Ruby said she expected all scores to worsen in session five due to an anxiety-provoking week, two significantly improved (including distress) and none significantly worsened. This may highlight that compassion was protective despite stressful life events.

Changes not due to expectancy artefacts. Ruby stated in the change interview that she had not expected any of the changes to occur, particularly as previous healthcare interventions had not resulted in substantial changes for her.

Changes not due to relational artefacts. Although the working alliance scores steadily increased across the course of therapy, Ruby's scores did not change steadily and consistently in accordance with this. This may therefore suggest that change was not due to the therapeutic relationship alone.

Statistical artefacts. Due to potential statistical inaccuracies, the affirmative case suggests that type II errors could exist for the other measures which report that no significant changes were made. Ruby commented that some of the wording in the questionnaires was confusing, particularly where negatively worded questions were used in the CEAS, which may have resulted in inaccuracy in capturing her experiences, and may explain why there were not clinical and/or statistically meaningful changes captured across all measures.

Conclusion. This affirmative case stipulates that:

- Ruby demonstrated substantial change in her problems.
- Ruby attributed these changes to therapy, even if her scores did not immediately correspond with significant sessions.
- The therapist attributed most of these changes to therapy.

- This evidence contradicts sceptic non-therapy reasons for change and/or lack of change.

This evidence provides a basis for you to:

1. Support the case that Ruby changed substantially during the period of therapy; and

2. Draw the inference that this change was caused by Ruby's participation in the CFT intervention.

***Sceptic Case**.* Any relevant pieces of evidence for Ruby will be explored below.

Trivial or negative changes on measurement. Although Ruby's PQ score change was statistically significant, this remained within clinical caseness at end of therapy, as did her CORE-5 score.

Statistical artefacts. In addition to potential statistical inaccuracies, it is possible that Ruby misinterpreted the wording of questions in measures or completed them in a way which inflated apparent improvement.

Relational artefacts. Ruby referenced a positive therapeutic relationship and found therapist attributes very helpful, so this may have influenced the way she appraised the helpfulness of the therapy, or in assuming the therapeutic intervention itself enabled change. Additionally, the WAI-O-S scores steadily increased over the course of therapy (aside from one outlier), so the strengthening of the therapeutic relationship could have been responsible for perceived changes.

During the session where the affect regulation systems were explored, which Ruby reported as particularly helpful, there was a positive increase in the therapeutic relationship. This may explain why Ruby perceived this aspect as helpful, rather than the CFT-specific technique itself being pivotal.

Expectancy artefacts. In response to the question, "at this point, how much do you really *feel* that the sessions will help you to manage your

difficulties?" Ruby scored 4 out of 7, indicating 'moderately.' This indicates that she had some expectation of the therapy being effective for her. This effect may have been inflated for Ruby as she had previously agreed with the SCP that trauma-focussed work would be inappropriate at this time. Subsequently, the worries and anxiety she reported at assessment may have manifested as high expectations and pressure on the intervention to be effective.

The following explanations as suggested by Elliott (2002) stipulate that change has occurred but not due to therapy and is therefore due to the following factors: 5) self-correction, 6) life events, 7) psychobiological factors, and 8) reactive effects of research participation.

Self-correction and other factors. Ruby reported at the assessment session that she had been practising relaxation techniques with her CPN from the perinatal team. As time passed and Ruby continued to practise these techniques, this could have been responsible for change which occurred. However, Ruby also reported in the change interview that despite having various interventions prior to the CFT intervention, she had not experienced significant changes.

*Lack of evidence for outcome-process mapping***.** Upon completing the end of therapy measures in session five, Ruby stated that she had experienced an anxiety-provoking week due to midwifery and consultant appointments, and that her scores were subsequently represented as more severe than they actually were on a weekly basis towards the end of therapy. Despite this, all her scores improved (two significantly) apart from her 'compassion to others' score which very slightly worsened.

*Life events***.** Ruby's problems were not stable and baseline scores could not be established, therefore it is difficult to know whether positive change would have naturally occurred. Ruby said that once the baby was born, she was very hopeful and optimistic that she would feel "back to normal again." Therefore, the anticipation of the birth may have been responsible for the improvement in Ruby's scores over time. Additionally, as Ruby had experienced PTSD from her first birth, the passage of time and gentle exposure to the

trauma (as she occasionally chose to discuss this in sessions) may have been responsible for the changes, as per research on exposure as a PTSD intervention (e.g., Hembree, Rauch, & Foa, 2003). Similarly, as sessions were held in her GP surgery, the presence of medical equipment and medical bed nearby may have assisted with the exposure process, even though Ruby stated that she did not feel anxious or 'triggered' attending the GP surgery.
Prior to midwifery and consultant appointments, Ruby said thoughts of being out of control and feeling mistrust of professionals arose in her and resulted in the anxiety she experienced. This did not seem to change until attendance at her birth plan appointment, following which her anxiety hugely reduced. This suggests that the CFT intervention was not responsible for changes in this area or reductions in Ruby's anxiety generally.

*Psychobiological factors***.** Although not reported by Ruby, changes in hormones may have contributed to fluctuated in mood, distress, or compassion.

*Reactive effects of research participation***.** When meeting for the initial session, Ruby described feeling excited and motivated to take part in the research not only because she had hoped she might benefit from the therapy, but also because she had attended the same university as the primary researcher and wanted to support this. Therefore, Ruby may have experienced participant bias in that she wanted to help create a strong piece of research with promising results, and this could have influenced reported changes.

Improvements not maintained despite life stressors. Follow-up data had not yet been collected at the judicial stage to assess whether incubation effects existed. However, Ruby reported experiencing peaks in anxiety prior to midwifery and consultant appointments, yet it would be hoped that the intervention would protect against this.

Lack of event-shift sequences. Ruby's scores did not consistently decrease over the intervention even when changes were made from pre-therapy to end of therapy. Additionally, changes did not necessarily coincide with events which Ruby reported as anxiety-provoking and predicted would affect her scores. Any changes in scores in accordance with these external events were not consistent amongst all measures and were not sustained.

This sceptic case stipulates that:

- Ruby did not make significant improved changes.
- Ruby did not attribute these changes to therapy.
- Any minor changes made were due to extra-therapeutic factors.
- This evidence contradicts evidence presented by the affirmative case.

This evidence provides a basis for you to:

1. Reject the case that Ruby changed substantially during the period of therapy; and

2. Draw the inference that any change was caused by extra-therapeutic factors.

3.2 Judges' theoretical orientations

- Considering the judges' own theoretical orientations and experiences, the judge with the most experience using CFT and working with perinatal populations was also the judge who most closely aligned with the CFT model. In two out of three participant cases, this judge rated highest with regards to level of change, likelihood that changes were due to therapy, and that changes were more likely due to CFT-specific processes than generic therapy factors. There were no consistent patterns in differentiating the judge who least identified with the CFT model.

4.0 Extended Discussion

4.1 Consideration of participant differences

The first participant, Anna, who did not experience significant changes and also corroborated this in self-report, noted that she found the concepts within CFT "woolly" and "wishy washy." During the intervention, conversations were had surrounding this which the participant reported as helpful and enabled her to connect more with the concepts. However, in the CI interview she stated that she still found it difficult to emotionally understand the ideas, even if she was able to intellectually understand them. This theme was explored in more detail within the sessions and formulated as a common life experience for her. Anna reported that any benefit she had experienced may have been due to her increasing mindfulness activities. When discussing mindful activities, Anna stated in the session that she was "already doing that without realising" yet a core aspect of mindfulness is the intent to purposefully engage in one activity. Although prior mindfulness practice (if this had occurred) had not had a significant impact on Anna's mental health difficulties, it may have been the weekly 'check in' regarding these practices which encouraged her to practice more frequently.

The second participant, Claire, reported only positive changes during the CI and stated that she had changed in ways she had not expected and regarding all the ways in which she had hoped, yet this was not reflected in the quantitative data i.e. the outcome measures. Although some statistically significant change occurred on the psychometric measures, these were not accompanied by clinically significant changes. This contradiction between self-report and quantitative data is interesting, and could be accounted for by a number of potential explanations: the participant experienced difficulty in completing the measures (she stated in sessions that she found some of the wording confusing), the measures did not capture the intended processes, the participant felt unable to be truthful in the CI (although working alliance scores were lower than for the other two participants), and/or statistical artefacts affected the clinical cut-offs and reliable change index calculation which were

approximately calculated due to lack of published clinical norms for the CORE-5, CEAS, and OAS.

The final participant, Ruby, may have engaged more effectively with the intervention due to a lack of previous mental health difficulties, which may have allowed her to connect with concepts such as self-compassion more easily. Additionally, Ruby was more easily able to draw upon and re-experience instances where she had demonstrated compassion towards others, which Anna found difficult to emotionally connect with. Although Claire identified multiple instances of compassion to and from others (primarily her children), she found it more difficult to reflect upon how this felt physically and emotionally, which may have hindered her ability to connect to the intervention as deeply. Ruby was optimistic that her mental health difficulties would drastically reduce once she had given birth, and this may have encouraged self-compassion as she was able to soothe herself with this knowledge and faith, as per the theory of the 'soothing system' in CFT. Conversely, this knowledge alone and gradual approach towards her due date likely improved her psychological wellbeing. Gentle exposure to discussing the previous trauma may have also assisted with this process, as Ruby began describing associated thoughts, feelings, memories, and dreams which she had previously felt completely unable to discuss with professionals and personal acquaintances. This may have also enabled more positive psychological wellbeing, which would reduce distress, as per the outcome measures. Subsequently, changes on the process measures could have been due to a reduction in guilt and shame which was initially associated with the distress Ruby felt, suggesting that a bi-directional causal relationship is possible and direction of causation is difficult to clarify. Although Ruby's mindset (optimism about the birth and no past history of mental illness) may have encouraged more intensive practice which was beneficial, she did report CFT-specific techniques themselves as very helpful.

4.2 Considering of study findings against existing research

As there is very little existing research for the perinatal population, and antenatal population in particular, any research contributes to existing literature

and is valuable regardless of whether CFT was effective. In the pursuit of investigation into psychological interventions for this population, it is equally important to understand what may not work so well. In consideration of the judicial responses, change across all three participants was low, as average judicial scores suggested 20-30% change in two participants and approximately 63% change in one participant. However, change largely appeared to be due to therapy (average scorings ranging from 67%-80% due to therapy). Importantly, average scores across the judicial panel indicate that change appeared slightly more due to generic therapy than CFT-specific aspects or techniques. A proof of concept pilot study has initially compared compassionate mind training (CMT) with CBT for women with postnatal depression, which suggests similar efficacy for both treatments yet indicates that CMT is superior in reducing symptoms of anxiety and depression (Kelman et al., 2016). This study does not seem to support these findings as all three women exhibited symptoms of anxiety, and one participant also reported chronic depressive symptomology. Although the Kelman et al (2016) study did not focus on mechanisms of change, there appeared to be a clear differentiation between the two interventions. Conversely, within this study all participants reported that the formulation process was helpful, yet it is unclear whether the CFT aspect of the formulation is pertinent. This study partially supports existing research which suggests that interpersonal psychotherapy (a structured psychological intervention) does not successfully prevent further mental health difficulties for the mother (Dennis, 2005), however Ruby's follow-up data indicated continued improvements at three months post-therapy. Two participants reported clinical appointments as heavily impacting upon their mood and distress, which may reflect the pivotal influence of pregnancy-related professional contact.

Dennis (2005) conducted a Cochrane review of preventative psychosocial and psychological interventions for depressed perinatal women (during pregnancy or up to five weeks post birth). Interventions included physical postnatal care such as postnatal and antenatal classes and professional home visits, but also included psychological interventions such as debriefing and interpersonal psychotherapy (Dennis, 2005). Dennis found that amongst these studies, the

only clear preventative intervention was intensive postnatal support provided by a health professional. Interestingly, this review found that interventions with a purely postnatal focus were more beneficial for the women than interventions which included an antenatal focus (Dennis, 2005). It is unclear whether this pertains to physical or psychological interventions, but all participants in this study generally reported that pregnancy was a hindering time to engage in therapy. Although one participant reported that it also encouraged her to engage in therapy, physical discomfort, clinical appointments, and preparation for birth remained problematic for all participants. However, it is perhaps unlikely that postnatal interventions would enable more time to be spent on therapy due to competing demands from a young infant, and this may instead reflect theories of motivation to change (DiClemente & Prochaska, 1998; Prochaska, DiClemente, & Norcross, 1992).

Participant reports were varied with regards to whether the intervention was easily understood, well-tolerated, helpful, and effective, which contradicts existing research findings (Judge et al., 2012). Although the participants in this study did not report difficulties in understanding the intervention, one participant reported that the psychoeducation aspect was overwhelming and that the concepts were difficult to understand on emotional level. This may have reflected the way the intervention was delivered and the focus of the session. However, all participants spoke positively about tolerating the intervention and the actual experience of taking part, with one participant explicitly comparing it to CBT and describing the ease at which she engaged with this model. Additionally, level of change and 'effectiveness' was varied across participants within this study.

4.3 Extended clinical and theoretical implications

Particular consideration will be given to examining whether helpful aspects of therapy named by clients are truly CFT-specific techniques or whether due to the integrative nature of CFT it is difficult to ever state that CFT itself was responsible for change, particularly without clinically validated process measures.

Psychoeducation. One participant had previously accessed CBT therapy yet commented on the usefulness of CFT-specific psychoeducation, although a lack of explicit comparison does not necessarily suggest CFT psychoeducation was more effective, or that the CBT intervention even offered this aspect. The psychoeducation aspect of this CFT intervention was the sole focus of session one and re-visited during each session. In this way, this component may be prioritised more strongly in comparison to other therapeutic models. The frequency and depth of psychoeducation could therefore have contributed to the reported usefulness as participants may have felt more empowered as they gained further knowledge about the source of, and intervention opportunities, regarding their difficulties (Gonzalez-Pinto et al., 2004). Conversely, one participant found the psychoeducation component particularly challenging and overwhelming.

Formulation. Although participants referenced specific aspects of the formulation, it is difficult to know whether it was these aspects in themselves which were responsible for change, or whether the generic formulation process itself was pertinent and the participants were simply recalling aspects of this.

Mindfulness. All participants referenced mindfulness as providing helpful techniques. Both mindfulness and compassionate approaches also encourage participants to become more aware of their own needs, and this process may encourage behavioural manifestation of self-care and subsequent improved wellbeing. Although CFT incorporates a mindfulness component, some mindfulness training programmes also focus on self-compassion more explicitly, for example during loving kindness meditation (e.g., Woolhouse, Mercuri, Judd, & Brown, 2014). In consideration of delivery of a CFT intervention for antenatal women, delivering this in an earlier stage of pregnancy may protect against hindering factors which participants reported were specific to being heavily pregnant. This included consideration of mindfulness activities which focussed on breathing and the abdomen region, as participants reported that this was uncomfortable due to the size and position of

the foetus, and that bringing attention to this was hinderance in attempting to engage in mindfulness.

Therapeutic relationship. Two participants referenced the importance of the therapist's approach/therapeutic relationship in aiding change. This supports abundant existing research regarding the importance of desirable therapist qualities and the positive therapeutic relationship in client change occurring (Castonguay & Beutler, 2006; Wampold, 2007).

Thought challenging. One participant referred to a 'compassionate thought challenging technique' within session and said this was very helpful in reducing distress. However, thought challenging is most commonly used as part of the CBT model (e.g., Beck, Rush, Shaw, & Emery, 1979). However, it could be argued that the compassionate aspect of the thought challenging may be specific to the CFT model in that it aims to reduce shame surrounding 'irrational thoughts' so that the client non-judgementally accepts their thoughts as valid but also seeks to reduce their distress (Leaviss & Uttley, 2015).

Validation. One participant said it was helpful to consider that, "it's okay to feel how I'm feeling." This approach is consistent with CFT rather than models such as CBT which aim to elicit change in participants via identification of unhelpful behaviours and cognitions (Beck, 1976). However, this validation and acceptance of feelings is also key in the ACT approach (Hayes, Strosahl, & Wilson, 2002), which may emphasise the importance of this validation process during therapy rather than the entire CFT model.

Existing literature suggests that if the mother is less stressed then the foetus is also less likely to be stressed and subsequently experience physical or behavioural difficulties once born (Hobel, Goldstein, & Barrett, 2008), thus likely perpetuating positive wellbeing for the mother. A psychological intervention during pregnancy could therefore provide delayed positive affects following birth but this data is not captured, and subsequently participants may believe the intervention was ineffective if these links have not been explicitly made. However, considering that most individuals attending therapy seek to experience a reduction in distress as quickly as possible, these potential

delayed effects may still represent a perceived ineffective intervention if distress has not been clearly reduced during pregnancy.

Compassion and shame in perinatal women. Interestingly, all participants scored highly with regards to expression of compassion towards others, but much lower regarding their belief of how much other people expressed compassion towards them. This may reflect common mental health disorder symptomology and subsequent cognitive biases experienced by participants, for example, negative predictions about others which commonly occurs in depression (Carnelley, Pietromonaco, & Jaffe, 1994), and viewing others as threatening when experiencing anxiety and PTSD (Ehlers et al., 1998). This may also reflect participant assumptions regarding how they are viewed and treated by others, which may arise from existing beliefs or pregnancy. As one participant described no previous history of mental health difficulties prior to a single traumatic event, this may suggest a role for appraisals which specifically occur during pregnancy regarding how other people view and respond to them. For example, if women experience a lack of control over their bodies when attending midwifery appointments (Rudolfsdottir, 2000), which could be framed as a lack of compassion. This experience may have been particularly pertinent for this participant as her mental health difficulties arose from a previous traumatic birth. Discourses (and pertinent practicalities) surrounding motherhood commonly include the notion of sacrifice, adhering to ‘rules’ which adapt according to research and trends, and frequently reported critique from society and immediate contacts regarding how to be a mother or look after the infant. Subsequently, this may affect the ability for antenatal women to be more self-compassionate if these competing demands, conflicts, and challenges, are experienced as all-consuming and leaving little room for self-care. Additionally, these discourses could understandably lead to the experience that others express little compassion towards them. This could contribute towards a further explanation of a CFT intervention as having limited effectiveness for antenatal women, although this contradicts (albeit sparse) existing research (e.g., Cree, 2015; Kelman et al., 2016).

Mental health diagnoses. Lastly, the participant for whom CFT appeared most effective, experienced a single discrete trauma leading to her current mental health difficulties, and had reportedly not described any mental health problems prior to this episode. Conversely, the other two participants for whom CFT was less effective reported a longstanding chronic history of varying mental health difficulties. This may suggest that a CFT intervention is more effective and appropriate for targeting a specific discrete difficulty, or that a much longer intervention is required for individuals with long-standing MHD. Although this was not explicitly commented upon by participants, one suggested that she now felt more able to continue with further therapeutic intervention, and this intervention may therefore serve as a pre-therapy intervention to aid future input and subsequent client change.

4.4 Research implications

As psychological research focussing on antenatal women is sparse, further investigation and empirical research is required to examine the most effective psychosocial interventions. Future RCTs could utilise a stratified sampling method to assess women in progressive stages of pregnancy in order to assess whether the stage of pregnancy affects effectiveness of an intervention and how interventions could be adapted to improve effectiveness. Given that participant feedback within this study referenced requirement of further practise and technique implementation, and that one participant specifically said they would have found it helpful to practise further techniques with the therapist, research investigating a longer CFT intervention may highlight whether this would be useful in aiding application. However, the length of psychological intervention does not currently appear to be correlated with psychological outcomes, with no suggestion that an increase in sessions results in more therapeutic benefit (Clatworthy, 2012).

Regarding use of formulation, a comparison of different approaches may highlight whether pertinent and more effective aspects of formulations exist as, for example, some formulations emphasise the role of past experiences whilst other focus purely on current difficulties. The language used during the formulation process may also impact upon the client's therapeutic trajectory, as

CFT formulations consciously utilise language which discourages shame and frames client responses as understandable given their experiences. It may be interesting to consider whether formulations which may intentionally decrease shame and reduce emphasis from personal responsibility serve to empower the client in actively making changes, or whether this language perpetuates psychological distress.

4.5 Study limitations

4.5.1 HSCED method. Although the HSCED draws upon numerous data collection and analytic methods, the CI in particular requires advanced reflective and insightful skills from the participant. For a client to reflect upon changes, consider whether these would likely have occurred without therapy, and to reflect upon personal attributes and events which may have affected outcome, is highly demanding of the client. It is difficult to predict whether the client would have made changes without therapy, although considering the stability of the client's difficulties assists in making this attribution. However, reflections and attributions are subjective by nature and client experience is valued by this method, as is the therapist view which is also presented in case records.

4.5.2 Mitigating bias. Although attempting to reduce researcher bias, a positivist perspective would suggest that the adjudication process provides opportunity for bias in consideration of the validity of judicial conclusions. However, as the HSCED method and pragmatic constructivist position challenges the notion of purely unbiased research and instead priorities transparency and self-reflective research processes, judges were treated as quasi single-case studies and as offering a positive source of variance. These differences were also captured in the preliminary judicial questions.

The judges were also considered 'independent' of the research project, although all three worked for the Trent doctoral course as part of the University of Lincoln and University of Nottingham. Although bias may have existed during this analysis phase, no direct conflicts of interest were apparent or stated. As the primary researcher also acted as the intervention therapist, researcher bias may have occurred as a result of conflict of interest. However, the primary

researcher did not have a particular commitment or affiliation to the actual CFT model and adopted the position that if the intervention was ineffective then this was equally important in contributing to the research base for this client group. Steps were also taken to mitigate effects via use of a CFT protocol and subsequent adherence checks, judicial review, and weekly supervision.

4.5.3 Acquiescence. The CI was conducted by an external researcher (not part of the research team) with whom participants had no prior relationship, in an attempt to reduce participant bias. However, participants were aware that the primary researcher would access this data, and therefore participants may have still felt compelled to adjust their answers accordingly. In an attempt to examine this, one of the CI questions pertains to whether the participant was impacted by the research project. However, acquiescence or participant bias may have potentially occurred during the process of completing self-report measures each session. As the participant was aware they would meet with the therapist each week, they may have been inclined to complete measures in accordance with maintaining the therapeutic relationship. However, the decision to administer self-report measures was to reduce the likelihood of missing data and allow opportunity for the participant to ask any questions or clarify the meaning of questions, which commonly occurred and subsequently may have increased accuracy of completion. Additionally, fluctuations in distress scores did not imply this was occurring, and an observer-completed working alliance measure aimed to reduce ceiling effects arising from participant-reported working alliance.

4.5.4 Measures. Although the CORE-10 provides published psychometric data which positively supports aspects such as internal consistency and test-retest reliability, this data is not yet available for the CORE-5 which is a limitation of this measure's use. However as previously cited, measurements for the CORE-5 regarding the alpha coefficient and evaluation against PHQ-9 (Kroenke et al., 2001) items have been strong (Barkham et al., 2010).

The process measures (OAS and CEAS) were chosen due to their development by the founder of CFT and also in consideration of face validity and strong reliability in existing research (Gilbert et al., 2017). However, due to limitations in existing research regarding clinical norms which were required in order to calculate the reliable change index and clinical caseness, crude calculations were again required in assessing (part of) the quantitative change by calculating approximate clinical norms using standard deviations from non-clinical populations, and also requiring use of non-clinical norms in assessing clinical caseness.

A shortened version of the original WAI-O form was utilised in this study, which has been less researched than the original WAI and WAI-O forms. A disadvantage of this shorter measure is in the reduced number of items which may have subsequently neglected a larger breath and specificity of aspects which contribute to the working alliance. However, this shorted observer version was chosen to avoid ceiling effects in measures completed by participant or therapist, and in an attempt to reduce researcher bias. The working alliance was completed by an observer using audio tapes rather than video tapes of sessions. This decision was made in order to reduce any additional pressure for participants who may have felt more distracted or uncomfortable with video-taping, although audio alone does not allow for consideration of explicit cues such as body language, which may indicate important factors regarding the working alliance.

Regarding the CEAS, there was a surprising lack of within-clinical caseness scores pre-therapy. Reasons for this may include crude clinical caseness calculations, validity of the measure itself, difficulties for the participant in completing the measure, or challenges to the link between shame and lack of compassion. All three participants reported high levels of guilt and shame which were corroborated by the perinatal team working with the client, in assessment by the SCP, and also assessed in the preliminary session with the primary researcher. However, all three participants scored below clinical caseness at assessment. Interestingly, the OAS measurement of shame appeared more representative of participant-reported and clinician assessment. Guilt and

shame may therefore be easier to spot than lack of compassion itself due to the presence of the critical voice which may frequently be articulated during assessment. Although this would contradict existing research and theory (Gilbert & Procter, 2006; Mosewich, Kowalski, Sabiston, Sedgwick, & Tracy, 2011), perhaps this study highlights that clinically high levels of shame do not necessarily correlate with clinically low levels of compassion. Similarly, levels of compassion may be very difficult to measure in clinical assessment and therefore this is only assumed if high levels of guilt and shame exist.

4.5.5 Change interview. Within the change interview two participants spoke of needing further time to implement techniques to assess whether lasting change occurred. Therefore, the change interview may have been conducted too soon after the end of the intervention and waiting two or three additional weeks may have enabled further participant reflection and insight. With hindsight it would have been prudent to be firmer with the interviewer conducting the change interview regarding the questions asked and in ensuring sufficient exploration of helpful aspects of therapy were conducted. Specific details such as when the helpful event occurred and rating the helpfulness of the event were often neglected by the interviewer which made it more difficult to ascertain helpful aspects of therapy, although fortunately clients discussed this in other parts of the change interview.

5.0 Critical Reflective Section

5.1 Dual role of therapist and researcher

Although traditional research methods such as RCTs and other experimental designs emphasise exertion of high control over variables, the HSCED method prioritises utilisation of the naturalistic context in investigating causal links. This method recognises that clinical practice is rarely represented in research whereby high levels of control exist, and instead aims to increase the likelihood of clinical application of research findings (Elliott, 2002). Subsequently, this method seeks to recognise and consider the impacts of contextual effects and display transparency regarding issues such as bias (Elliott, 2002). This was an important consideration for me as I found myself conflicted during the initial planning process where one supervisor and I suggested that the SCP[30] conducted the CFT intervention. Our rationale for this was that the SCP used CFT as part of treatment as usual for some clients, was more experienced in this modality, and that I could then focus all my efforts on the research process. However, the SCP (at that time) advised that due to service pressures she was not able to commit to this (as some of these clients may have instead accessed a group rather than individual therapy), and that she felt this was an important clinical experience for me in strengthening my CFT skills. My secondary supervisor and I were also concerned about the potential bias which may occur as a result of this dual role, but after learning more about the HSCED method I understood that this could be treated openly and curiously, rather than viewed as a hindrance. However, I certainly experienced additional pressure in that I needed to train in CFT, become well acquainted with the model and therapy protocol, and travel outside of my local area on my study days for a number of months. Upon reflection, although having another clinician deliver the intervention would have potentially reduced my stress levels, adopting this dual role assisted during the analysis process as I could reflect on the sessions with a higher level of insight than relying on report only (as per Elliott's recommendations; 2002). Subsequently, I was able

[30] Also acted as my primary supervisor at that time before leaving the post.

to place process notes and session recordings within the context of the client and session as I had a deeper understanding of this. I found that participants did not mention information which I considered pertinent within the change interview, for example, if the participant had spent time in sessions discussing life events or utility of techniques yet had not described this in the interview. This may reflect a limitation of change interviews and reliance on memory and recall yet may also reflect an assumption as the therapist in what was considered important to that participant. Although information used in sessions was utilised as part of the clinical case record, it was important to review the CI transcript to ensure I had recorded the source correctly and demonstrated transparency regarding any suggested attributions. Whilst my assumptions as a therapist may have influenced the way I collated and presented the data, the adjudication process assisted in encouraging external perspectives and challenging any biases I presented. I expected that critical reflection on my skills and qualities as a therapist would be challenging, and I recall feeling anxious when listening back to the change interview in case participants stated they found me unhelpful or unpleasant as a therapist. I discussed this with my supervisor who advised that this would remain useful data in considering interventions and approaches which might be helpful for this client group. However, I believe it would have been difficult to hold this in mind if this happened, as I would have experienced my own guilt and shame in relation to my performance as a therapist for these participants and within previous services where I had delivered CFT. My use of research supervision and CFT supervision assisted me with my position as a critical-reflective researcher, as did my reflective journal whereby I aimed to utilise self-compassion to manage these feelings, as per the techniques I discussed with participants. It was important to recognise and work through these feelings so that the research process remained as stringent as possible and so my personal anxieties did not affect the process at each stage. This conflict between research goals and therapeutic goals or focus has been highlighted (Gabriel, 2005) and ‘ethical mindfulness’ is recommended throughout as a way to highlight and work through these experiences (Bond, 2015), which I consistently strived to adopt.

Throughout this process I have become well acquainted with the CFT model which I have since used in my clinical practice. Additional weekly supervision also strengthened my skills in reflecting upon my practice and adapting protocols appropriately to meet client needs. Furthermore, working with this client group has strengthened my clinical skills, such as consideration of discomfort during mindfulness activities and in reflecting upon how societal discourses impact upon how a person relates to themselves.

I kept a reflective journal throughout the intervention and have presented some extracts from this regarding each participant. Please see Appendix L.

5.2 Participant pregnancy

As the research question and aims focussed on interventions for pregnant women, the time-limited nature of pregnancy was considered a challenge to this research study. The perinatal team only accepted referrals for women in their second and third trimesters due to increased rates of miscarriage prior to the second trimester (Garcia-Enguidanos, Calle, Valero, Luna, & Dominguez-Rojas, 2002). Subsequently, women would sometimes be referred into the service in their third trimester which meant that identification of potential participants, booking in clients to be assessed by the SCP, booking to meet with myself and subsequently completing the intervention, put pressure upon these time constraints prior to the birth. This was particularly evident if participants needed to cancel a session due to illness or plans such as holidays as I would continuously calculate the number of weeks remaining before their due date, whilst acknowledging that labour onset could be unpredictable. Additionally, I unexpectedly needed to take one month off work prior to starting the intervention with my first participant. I felt enormous guilt regarding this as I feared that I was replicating prior relationships she had experienced with services who had “let me down.” However, discussion with my supervisor revealed that fitness to practise is of supreme importance in both clinical practice and research, and that it could have been damaging to have started the intervention with this client at that time. Although I became aware of my own self-critical voice, openness and honesty in exploring this with my supervisors was paramount. In all honesty part of me was also anxious that participants

may go into labour during the intervention – not only in terms of not completing the intervention but also literally in a session. I was able to share these feelings and use humour with the SCP regarding this, although I recall one participant experiencing Braxton Hicks contractions and my anxiety rushed back for this brief moment.

I remember feeling very conflicted when a participant advised that she wanted to meet with the SCP to discuss another intervention. Although I had clearly outlined to participants at the beginning of the intervention that we would be focussing on CFT techniques specifically and there would be little time to discuss other issues, I felt concerned and ashamed that this request potentially suggested she wasn't benefitting from the intervention or connected with me as a therapist. I discussed this with the SCP who advised that this participant wanted to explore a specific difficulty which the CFT intervention could not provide, which reassured me slightly. However, I was also concerned in terms of participant numbers that she would not have completed the intervention. The SCP and I discussed this in detail, and I suggested that ethically if she felt another intervention would be more helpful then this should be pursued immediately, as per the 'right to withdraw' which was outlined to participants. Regarding the research process, the SCP, my research supervisor and I all agreed that an assessment with the SCP would be appropriate but that if it was agreed that an intervention was possible then the participant would need to choose which one to pursue at that time. However, the participant chose to continue with the CFT intervention.

5.3 Rich case records

I found this process interesting but also extremely time-consuming. I noticed that whilst I used Elliott's guidance and categories of change, the way I organised the data and provisional attributions, were very subjective. At times I was unsure how far to 'pick apart' the data and each piece of evidence, and how relevant this would be. For example, when one participant reported that I was reliable and predictable, I was interested in exploring what function this served for the participant yet realised if I explored each quote or piece of data in this level of detail the report would become uncontained and confusing which

would potentially derail the research aims. Similarly, I was keen to provide a deep level of detail during data analysis for presentation of data for the judges but was aware that the amount of data could have potentially become overwhelming. My supervisor and I spent time exploring different ways of presenting this data and in considering whether there was an unnecessary level of detail for the judges. I was also anxious about utilising the reliable change index as this was a form of statistical analysis which I was less experienced with, particularly as difficulties calculating these emerged. This process took a long time and I utilised support from various sources who at times were unsure of the way to proceed. I subsequently experienced brief periods of learned helplessness where it appeared that no matter how much reading, research, and support I engaged with, I did not feel I was progressing with the analysis. This feeling was worsened when I submitted my accounts to the judges and on two occasions was (kindly) informed that one calculation was incorrect (the PQ), and that an alternative (and likely more accurate) scoring system existed for the CORE-5. The CORE-5 scoring required particular attention as it emerged that there were two ways in which this could be scored and subsequently interpreted. I had initially used the raw CORE-5 scores and halved the CORE-10 reliable change minimum and clinical caseness scores, in order to maintain the raw CORE-5 scores. However, once the alternative scoring system was brought to my attention by the judge, my supervisor and I agreed to adopt the existing CORE-10 published norms to enhance accuracy of these quantitative calculations, which required multiplying the raw score means by ten to enable these comparisons. Whilst I felt this made sense in a more accurate reliable change and clinical caseness calculation, I was concerned that the raw data were adapted and that an assumption was made that a direct multiplication would no longer represent the participant's experience. However, the rationale provided for this by experienced researchers helped reduce this anxiety hence why this decision was made.

The process of reviewing all the data, re-scoring this, adjusting the case records, and emailing the judges with updated summaries was exhausting and I again experienced high levels of shame. I felt incredibly anxious regarding the

idea that I would need to email the judges after they had submitted their reports, to advise that a mistake had been made and they would potentially need to review their submissions. However, the judges did not exhibit any resentfulness or anger, and my supervisor encouraged me to remember that accuracy and updated information was more important for the research than my anxious predictions.

5.4 Personal reflections

I have noticed during these reflections that I frequently experienced guilt, shame, and self-criticism throughout this process. I am aware that my self-critical voice has been pertinent during the process of the doctorate course, but I hadn't realised how much it had emerged during this research process which may have partially been due to this reflective focus on the research process itself. However, I did believe this could be a helpful model for this population, and I wonder if my optimism was partially due to the fact I personally benefitted from researching and connected with some of the techniques myself, although this was not a conscious effort.

Although theoretically I was not invested in whether CFT was an effective intervention, I noticed I felt particularly driven by the passion and motivation to want to heal the participants' pain and distress, not just for them but also for their unborn baby. Therefore, I hoped that some aspect of therapy helped the participants, even if it wasn't the CFT model itself.

Following my initial research proposal being completed towards the end of first year, my supervisors and I decided the project needed to change due to the fact I had seemingly answered my research question via my extensive systematic literature review. Subsequently, my entire research proposal changed at the beginning of second year and the HSCED method was introduced to me. This was not a method I was familiar with and I felt anxious not only about the fact my research project was changing, but also that I needed to become well acquainted with an unfamiliar and complex research method. However, I really started to value the HSCED method and believed it reflected the way I approach research in valuing both quantitative and qualitative methods and that

careful consideration is given to the precise mechanisms of change rather than assuming the therapy model is the causal factor for any client change.
Following the change in project it was agreed that my second supervisor would change to reflect supervisory research interests and experiences. However, my primary supervisor then left her research post with the university mid-way through second year which resulted in my secondary supervisor becoming primary supervisor and a new member of staff becoming my secondary supervisor. As my primary supervisor also acted as my field supervisor as she was the SCP in the perinatal team, this supervisor also changed as another clinical psychologist took over this position. These multiple changes resulted in me feeling concerned that the supervisors may not be as invested in the project given it did not arise from their own research interests, and worried that much 'handover' would be required in ensuring I gained an appropriate level of support. Fortunately, the research team were very enthusiastic and supportive throughout this entire process, and I believe that this exposure to change reduced my anxiety regarding this overall, and I learned to accept the unpredictability of research.

5.5 Manualised CFT protocol

The use of a CFT protocol was considered integral to the intervention in order to enable some replicability in ascertaining whether certain sessions were found to be particularly helpful across participants. Additionally, the aim of this was to ensure 'key'[31] CFT techniques were utilised in sessions, particularly given that the intervention spanned only six sessions. Although manualised programmes can be advantageous for the therapist and client in containing sessions and maintaining focus (Addis, Cardemil, Duncan, & Miller, 2006), some suggest that manualisation negatively impacts the therapeutic relationship and client outcomes (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Henry et al., 1993) . However, good practice suggests that manualised programmes should also prioritise the therapeutic relationship and process, and crucially for this study, provides a guide for therapists in ensuring adherence to

[31] Techniques and psychoeducation which are commonly referenced in the literature and considered integral to the model by Paul Gilbert.

an intervention model and accompanying of treatment principles, which serves to increase internal validity of research (Addis et al., 2006). The limits of the intervention focus were clearly described to participants prior to consenting to the intervention, and during the CI none of the participants highlighted rigidity of the model as problematic or restrictive. The utilisation of a manual has been criticised in its application to clinical practice (Wilson, 2012), although as some services increasingly move towards an Improving Access to Psychological Therapies model (Clark, 2011), there may be more pressure to utilise a structured approach. The research team agreed that a manualised protocol was necessary in standardising the intervention, but that some degree of flexibility was essential in ensuring all participants understood the key aims of the session (e.g., communication style, use of language, amount of depth covered would be individualised) and that more time may be spent on pertinent aspects of the clients' experience or specific exercises removed if the client was uncomfortable. I sometimes found it difficult to strike the right balance between manualisation and client-centred therapy but found that during my supervision with the SCP we were able to navigate this. This was supported by adherence checks which were completed by a supervisor. If additional time needed to be spent in ensuring the client's distress was managed or in exploration of a (relevant) difficulty in relation to the key conversational points (e.g. "what are your challenges to demonstrating compassion?"), this was deemed appropriate as long as links were made to CFT concepts and essential aspects were covered[32]. These adaptations were also noted as part of the case records.

[32] Essential aspects and key conversational points were highlighted in advance of the session.

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Thesis Appendices

Appendix A: Search strategy

Medline

1. S1 ‘Postnatal psychosis’ (no thesaurus equivalent) – search as free text
2. S2 ‘Experience’ (no thesaurus equivalent) – search as free text
3. S3 ‘birth N5 psycho?s’
4. S1 OR S3 (=S4)
5. S2 AND S4 (=S5)

PsycINFO

1. S1 ‘Postpartum psychosis’ (PsycINFO thesaurus for ‘postnatal psychosis’) – search
2. S2 ‘Experience?’ – search
3. S3 ‘Life experiences’ – search (free text suggestion)
4. S5 ‘Experience or perspective or view or perception or attitude’ (thesaurus) – search
5. S6 ‘Experience?’ (free text) – search
6. S2 OR S3 OR S4 OR S5 – search (=S6)
7. S6 AND S1 – search

Scopus

1. "experience" "postnatal psychosis"
2. "experience" "postpartum psychosis"

CINAHL

1. S1 ‘Postpartum psychosis’ (CINAHL headings for ‘postnatal psychosis’) – search
2. S2 ‘Life experiences’ (CINAHL headings for ‘experience’, ‘explode’) OR ‘experience?’
3. S3 Free text search ‘experiences or perceptions or attitudes or views’ (CINAHL suggestion)
4. S4 Free text search ‘experiences of’ (CINAHL suggestion)
5. S2 OR S3 OR S4 (=S5)

6. S5 AND S1

BPS Publications

1. “experiences” AND “postnatal psychosis” (0 results)
2. “experiences” AND “puerperal psychosis” (1 result – “Living with puerperal psychosis: a qualitative analysis, Emma Robertson & Antonia Lyons)
3. “experiences” AND “postpartum psychosis” (0 results)

Ethos

1. “puerperal psychosis” OR “postnatal psychosis” OR “postpartum psychosis”

OpenGrey

1. “postnatal psychosis”
2. “puerperal psychosis”
3. “postpartum psychosis”

Appendix B: Justification for inclusion/exclusion criteria

Inclusion criteria.

(1) Research that considered first-person perspective of having postnatal psychosis.

This was specified as it seeks to directly answer the research question.

(2) Research focused on the experience of having postnatal psychosis.

'Experience' included any setting, context, or specific experiences e.g., the experience of the recovery process. This also covered all locations across the world, to determine whether postnatal psychosis is a cross-cultural phenomenon, or if cultural and societal differences become evident for future consideration.

(3) Qualitative methodology and analysis implemented.

Qualitative methodology was specified as this approaches enables exploration of the subject matter and experience.

(4) Participants were aged 18 years or older.

Adult participants were specified as younger participants may have very different experiences due to contextual, societal, biological, and psychosocial aspects which are specific with the experience of becoming a mother when an adolescent.

(5) Publication available in the English language.

The researcher's language is English, and resources did not allow for interpretations of research papers.

Exclusion criteria.

(1) Mixed methods papers where qualitative component could not be independently extracted.

It was essential that the qualitative data and findings were available for extraction and to be considered independently for the meta-synthesis.

(2) Mixed person accounts where first-person account could not be independently extracted.

It was essential that first-person accounts were available for extraction and could be considered independently to ascertain the experiences of the women diagnosed with postnatal psychosis.

(3) Research referencing multiple perinatal disorders, yet findings with regards to postnatal psychosis could not be independently extracted.

In order to answer the research question, it was crucial that the findings relating to postnatal psychosis were able to be independently extracted.

(4) If not original research.

For the purpose of conducting a high quality meta-synthesis, it was imperative that papers described findings of original research, including recruitment of participants and analysis of findings.

(5) Direct quotes not included.

First order and second order constructs need to be checked in order to ascertain accuracy of suggested third order constructs.

Appendix C: Critical appraisal of this review

CASP criteria	**Scoring**[33]
Did the review address a clearly focused question?	2
Did the author look for the right type of papers?	2
Do you think all the important, relevant studies were included?	1 – Non-English language studies were not included due to time and resource restrictions. Unpublished theses possessed by experts and not available on Grey Literature sites could have been missed due to time frame. Further databases could have been included, searched by multiple researchers if time and resource restrictions allowed for this.
Did the review's author do enough to assess the quality of the included studies?	1 – This was not checked by another researcher at this time.
If the results of the review have been combined, was it reasonable to do so?	2
What are the overall results of the review?	2
Can the results be applied to the local population?	1 – Due to limitations identified in review regarding population, settings and cultures.
Were all important outcomes considered?	2
Are the benefits worth the harms and costs?	2

[33] 0 indicates criteria unmet, 1 indicates partially met, 2 indicates fully met

Did the author clearly reference reflexivity?	2
Did the author clearly state their epistemological position?	2

Appendix D: Judicial questions

Preliminary Questions

1. Please rate your preference for use of a CFT model/approach in your practice in comparison to other therapeutic models.
   Please state the approximate percentage using the below guide:
   _____

Very strong preference for non-CFT model	Moderate preference for non-CFT model	No preference over other models	Moderate preference for CFT model	Very strong preference for CFT model
0%	25%	50%	75%	100%

2. Please describe any preferred therapeutic models/approaches you utilise, or have utilised, in your clinical practice.

3. Please provide a brief summary of any clinical experience you have using CFT.

4. Please provide a brief summary of any clinical experience you have working with perinatal populations.

Judicial Questions[34]

Please complete a set of these questions for each participant.

1A. To what extent do you think the client changed over the course of therapy?

Please state the approximate percentage using the below guide:

_____

No Change	Slightly	Moderately	Considerably	Substantially	Completely changed
0%	20%	40%	60%	80%	100%

1B. How certain are you?

Please state the approximate percentage using the below guide:

_____

Not at all certain					Extremely certain
0%	20%	40%	60%	80%	100%

[34] Adapted from Morris (2018) and Stephen et al., (2011).

1C. What evidence presented in the rich case record mattered most in reaching this conclusion? Why was this important and how did it help you make your decision?

Please name any specific ways in which they changed or did not change.

2A. To what extent is this change, or lack of change, due to CFT-specific processes? (i.e. techniques and focus on increasing compassion and decreasing guilt and shame)
Please state the approximate percentage using the below guide:

_____

Not at all due to CFT processes/ techniques	Slightly due to CFT	Moderately due to CFT	Considerably due to CFT	Substantially due to CFT	Completely due to CFT processes/techniques
0%	20%	40%	60%	80%	100%

2B. How certain are you?
Please state the approximate percentage using the below guide:

_____

Not at all certain					Extremely certain
0%	20%	40%	60%	80%	100%

2C. What evidence presented in the rich case record mattered most in reaching this conclusion? Why was this important and how did it help you make your decision?

Please name any specific processes or techniques you deem important.

3A. To what extent do you think this change, or lack of change, was due to other therapeutic factors? (e.g., common factors, generic therapeutic techniques, therapist factors)

Please state the approximate percentage using the below guide:

_____

Not at all due to common therapeutic factors	Slightly	Moderately	Considerably	Substantially	Completely due to common therapeutic factors
0%	20%	40%	60%	80%	100%

3B. How certain are you?

Not at all certain					Extremely certain
0%	20%	40%	60%	80%	100%

3C. What evidence presented in the rich case record mattered most in reaching this conclusion? Why was this important and how did it help you make your decision?

Please name any specific factors you deem important.

4A. To what extent do you think this change, or lack of change, was due to extra-therapeutic factors? (e.g., client's attributes, client's life events)

Please state the approximate percentage using the below guide:

_____

Not at all due to extra-therapeutic factors	Slightly	Moderately	Considerably	Substantially	Completely due to extra-therapeutic factors
0%	20%	40%	60%	80%	100%

4B. How certain are you?

Not at all certain					Extremely certain
0%	20%	40%	60%	80%	100%

4C. What evidence presented in the rich case record mattered most in reaching this conclusion? Why was this important and how did it help you make your decision

Please name any specific factors you deem important.

Appendix E: Letter of ethical approval

NHS
Health Research Authority
North West - Greater Manchester West Research Ethics Committee
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Telephone: 0207 104 8021

12 February 2018

Dr Vanessa Dale-Hewitt
YANG Fujia Building, B Floor
Jubilee Campus
Nottingham University
NG8 1BB

Dear Dr Dale-Hewitt

Study title:	**Compassion-Focused Therapy for individuals with antenatal mental health difficulties: A Hermeneutic Single-Case Efficacy Design**
REC reference:	**18/NW/0076**
IRAS project ID:	**235605**

The Research Ethics Committee reviewed the above application at the meeting held on 02 February 2018.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact hra.studyregistration@nhs.net outlining the reasons for your request.
Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

(Version 1.3: Date 13.08.18**)**

IRAS project ID: 235605

Title of Study: Compassion-Focused Therapy for individuals with antenatal mental health difficulties: A Hermeneutic Single-Case Efficacy Design

Name of Researcher(s): Sophie Wicks, Dr. David Dawson, Dr Sarah Ramsden, and Dr Katie Bohane.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

To increase our understanding of how Compassioned-Focused Therapy (CFT) can reduce distress (such as anxiety and depression) by reducing guilt, shame, and self-criticism, and at the same time increase compassion for self. Although there is research showing that this therapy is effective for reducing psychological distress (e.g., Barnard & Curry, 2011; Kelman et al., 2016) there is still a lot to learn about exactly how it works for individuals with antenatal mental health difficulties.

Why have I been invited?

You are being invited to take part because you are currently accessing support by the community perinatal service, and have expressed an interest in psychological therapy.

Do I have to take part?

No. It is up to you to decide whether or not to take part. You have been given this information sheet to help you decide whether you want to take part or not. If you have agreed, Sophie Wicks (trainee Clinical Psychologist and researcher) will be in touch after 24 hours to answer any further questions you may have about the project. She will also ask if you want to take part. If you do not want to take part, that is fine, and you will be seen by the Clinical Psychologist as soon as a session becomes available. The Clinical Psychologist will send you a letter about this. If you agree to take part in the study, you will arrange a time with the researcher to meet at a time that suits you.

What will happen to me if I take part?

If you agree to take part, you will arrange a meeting with the researcher will arrange to see you at a local NHS building (e.g., hospital building or GP surgery) for six individual sessions of Compassion-Focused Therapy, and an assessment/introductory session. At that meeting you will be asked to complete a consent form. Each therapy session will be individually tailored to your goals and needs and will last approximately 1.5 hours. All sessions will be audio-recorded so that a specialist CFT practitioner can listen to one session (picked at random) to ensure that the therapeutic model is adhered to.

You will be asked to complete four different questionnaires – some of these will be done before and after therapy, and you will be asked to complete some short questionnaires each session. These questionnaires aim to measure your view of your distress (e.g. anxiety,depression), therapy goals, and specific components of compassion-focused therapy.

Approximately two weeks after the final therapy session, an independent researcher will either meet with you at a local NHS building (e.g., hospital building or GP surgery) or offer a telephone interview (if this is your preference) at a time that suits you to discuss your experience of the therapy and any changes you have noted since engaging in the therapy. This discussion will be audio recorded and kept **strictly confidential** by a principle investigator at the University of Lincoln.

Finally, two short questionnaires will potentially be posted to you, if time allows, (1 and 3 months after the therapy) with a stamped addressed envelope for you to return them to the study team; These aim to measure your view of your current levels of distress (e.g. anxiety, depression).

Expenses and payments

Participants will not be paid to participate in the study. However, car parking and bus ticket costs will be reimbursed. Additionally, if you require but are unable to find childcare, a mobile creche will be paid for whilst you are attending the Compassion-Focused Therapy sessions and the meeting at the end of therapy.

What are the possible risks of taking part?

There are no likely risks of taking part in this study. You may be asked to discuss sensitive information. If you do become distressed during the study, the researcher is a trainee Clinical Psychologist who is trained to support individuals in distress. The researcher will also be able to liaise with the perinatal psychiatric team for further support if needed.

What are the possible benefits of taking part?

Compassion-Focused Therapy is an evidence-based therapy for reducing psychological distress, however we cannot guarantee this outcome. If, after the intervention you still require psychological input, you can continue to access psychological and or psychiatric input from the community perinatal psychiatric service.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Patient Advice and Liaison Service: 0800 092 0301

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of your medical records and the data collected for the study will be looked at by authorised persons from the University of Nottingham and University of Lincoln who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, we will use information collected from you during the course of the research. This information will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database at the University of Lincoln. Under UK Data Protection laws the University is the Data Controller (legally responsible for the data security) and the Chief Investigator of this study (Sophie Wicks) is the Data Custodian (manages access to the data). This means we are responsible for looking after your information and using it properly. Your rights to access, change or move your information are limited as we need to manage your information in specific ways to comply with certain laws and for the research to be reliable and accurate. To safeguard your rights we will use the minimum personally – identifiable information possible.

You can find out more about how we use your information and to read our privacy notice at:

https://www.nottingham.ac.uk/utilities/privacy.aspx.

The data collected for the study will be looked at and stored by authorised persons from the University of Lincoln who are organising the research. They may also be looked at by authorised people from regulatory organisations to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team given permission by the data custodian will have access to your personal data.

In accordance with the University of Lincoln, the Government's and our funders' policies we may share our research data with researchers in other Universities and organisations, including those in other countries, for research in health and social care. Sharing research data is important to allow peer scrutiny, re-use (and therefore avoiding duplication of research) and to understand the bigger picture in particular areas of research. Data sharing in this way is usually anonymised (so that you could not be identified) but if we need to share identifiable information we will seek your consent for this and ensure it is secure. You will be made aware if the data is to be shared with countries whose data protection laws differ to those of the UK and how we will protect your confidentiality.

Although what you say during the therapy and later discussion is confidential, should you disclose anything to us which we feel puts you or anyone else at significant risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible. If you wish, you will return to the service waiting list at the point you were taken from. Any further support you receive will not be affected by your decision regarding participation.

What will happen to the results of the research study?

You will be non-identifiable from study results. This study will form a Doctoral Thesis at the University of Lincoln, College of Social Science/Doctorate in Clinical Psychology. It will therefore be available to read by undergraduate and postgraduate students registered at this institution. The intention is to submit this study to a medical/psychological journal. Key results will also be disseminated to the perinatal services who took part in the project (potentially Lincolnshire, Derbyshire, and Nottinghamshire NHS Trusts) and made available to participants and posted to them on request.

Who is organising and funding the research?

This research is being organised by the University of Lincoln and is being funded by the National Health Service (NHS).

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests.

Further information and contact details

Sophie Wicks (Trainee Clinical Psychologist)

15623263@students.lincoln.ac.uk

College of Social Science/DClinPsy,

Sarah Swift Building

University of Lincoln, LN5 7AY

Dr. David Dawson (Clinical Psychologist; Academic Tutor on the Trent DClinPsy Programme)

ddawson@lincoln.ac.uk

Trent Doctorate in Clinical Psychology

University of Lincoln, Sarah Swift Building

Brayford Wharf East, Lincoln LN5 7AY

01522 837336

Appendix G: Participant Consent Form

Participant Consent Form

(Version 1.2: Date 13.08.18**)**

IRAS project ID: 235605

Title of Study: Compassion-Focused Therapy for individuals with antenatal mental health difficulties: A Hermeneutic Single-Case Efficacy Design

Name of Researcher: Sophie Wicks

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 1.1 dated 14.02.18 for the above study and have had the opportunity to ask questions. ☐

2. I understand that if I withdraw no further information will be collected about me but that the research team will keep any information about me that they have already obtained. This is because they are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard my rights, they will use the minimum personally-identifiable information possible. ☐

3. I understand that relevant data collected in the study may be looked at by authorised individuals from the University of Nottingham and University of Lincoln, the research group and regulatory authorities where it is relevant to my taking part in this study. I have read all information pertaining to how my data is used and stored. ☐

4. I understand and agree to completing some questionnaires before the intervention and at each session, and to engage in a meeting or telephone conversation with a researcher after the sessions, to discuss my opinion on the therapy. ☐

5. I agree that the information gathered about me can be stored by the University of Lincoln, for possible use in future studies. Any data used will be anonymised, and I will not be identified in any way. Anonymous quotes may be used in the finished report, providing that I cannot be identified by these. ☐

7. I agree to staff in the perinatal service being informed of any issues which arise, which may affect my physical or psychological health. ☐

8. I agree to all sessions being audio recorded, and for these recordings to be transported on an encrypted device or securely emailed. This is to ensure the correct therapeutic model is being followed and will be privately listened to by a clinical psychologist, with confidentiality maintained at all times. ☐

9. I agree to take part in the above study. ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

Participant Demographic Sheet

Date:

Participant name

_____

Participant ID

_____

Date of birth

_____

Ethnicity and race

_____

Employment status prior to pregnancy/during pregnancy

_____

Highest educational level achieved

_____

Marital status (if recent separation, state when)

_____

Current gestational age of foetus

_____

Current mental health diagnosis/es

_____

Approximate length of time since diagnosis/symptoms

_____

Details of any physical health difficulties during current pregnancy

_____

Is the current pregnancy considered physically high-risk?

_____

Have they taken drugs or alcohol during the pregnancy?

_____

Diagnosed co-morbid mental health difficulties

_____

_____

_____

Number and age of children (aside from current pregnancy)

_____

Details of mental or physical health difficulties with any previous pregnancies

_____

_____

_____

Details of any support received for non-perinatal previous mental health difficulties

_____

_____

_____

_____

_____

Details of any previous non-perinatal mental health difficulties

_____

_____

_____

_____

_____

Do they consider themselves to have ever suffered from trauma or extreme stress?

_____

_____

_____

_____

_____

_____

Was the current pregnancy planned?

_____

_____

How do they feel generally about the current pregnancy?

_____

_____

_____

Have they previously suffered a miscarriage, stillbirth or neonatal death?

_____

_____

_____

Details of current psychological/social/practical support received

_____

_____

_____

_____

_____

_____

_____

_____

_____

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

UNIVERSITY OF LINCOLN

Participant Debrief Sheet

(Version 1.2: Date 13.08.18**)**

IRAS project ID: 235605

Title of Study: Compassion-Focused Therapy for individuals with antenatal mental health difficulties: A Hermeneutic Single-Case Efficacy Design

Thank you for taking part in this study.

What did we do?

We carried out a research study to explore and understand the effects of a Compassion-Focused Therapy intervention on distress, for women with antenatal mental health disorders.

We asked you to take part in six sessions of Compassion-Focused Therapy (CFT), followed by an interview with a researcher to talk about your experiences. All participants took part in the same intervention.

Why was this research needed?

Perinatal mental health difficulties affect between 10-20% of women in the United Kingdom (UK) during pregnancy and in the weeks or months following childbirth.

We therefore feel it is important to understand what and how therapy may be helpful for women experiencing antenatal mental health difficulties, particularly as pregnancy, childbirth, and motherhood can leave women feeling anxious and distressed. Although, CFT has been found to be helpful in other populations, there is growing but limited evidence to date to show it improves distress antenatally. This research was conducted to add to that literature, but to also identify specifically, how and why this type of therapy works to reduce distress.

What will happen now?

Protecting your data is very important to us, and it will be kept securely stored in a locked filing cabinet on NHS premises for at least seven years. Any data which identifies you personally will be destroyed once the study is complete, and only your pseudonym will be available to research staff and students.

The information collected from you and other participants will be analysed to look at similarities and differences between your experiences. The findings will then be written up and potentially published in an academic journal to inform others. The findings will also be disseminated to the community perinatal services which took part in the study (potentially Nottinghamshire, Lincolnshire, and Derbyshire NHS trusts).

If you withdraw we will no longer collect any information about you or from you but we will keep the information about you that we have already obtained as we are not allowed to tamper with study records and this information may have already been used in some analyses and may still be used in the final study analyses. To safeguard your rights, we will use the minimum personally-identifiable information possible.

If you are experiencing distress after taking part in the study and would like some further support, please contact the perinatal service you have been referred to.

Contact details

Sophie Wicks (Primary researcher)

15623263@students.lincoln.ac.uk

College of Social Science/DClinPsy,

Sarah Swift Building

University of Lincoln, LN5 7AY

Dr. David Dawson (Clinical Psychologist; primary supervisor)

ddawson@lincoln.ac.uk

Trent Doctorate in Clinical Psychology

Sarah Swift Building, University of Lincoln

Brayford Wharf East, Lincoln LN5 7AY

01522 837336

Thank you once again for your time and participation in this study, it is very much appreciated.

Appendix J: The Change Interview schedule

General Guidance for Interviewer

This interview works best as a relatively unstructured empathic exploration of the client's experience of therapy. Think of yourself as primarily trying to help the client tell you the story of his or her therapy so far. It is best if you adopt an attitude of curiosity about the topics raised in the interview, using the suggested open-ended questions plus empathic understanding responses to help the client elaborate on his/her experiences.

- For each question, start out in a relatively unstructured manner and only impose structure as needed. For each question, a number of alternative wordings have been suggested, but keep in mind that these may not be needed.

•Ask client to provide as many details as possible

•Use the "anything else" probe (e.g., "Are there any other changes that you have noticed?"): inquire in a nondemanding way until the client runs out of things to say

Recap of Sessions

(if participant requires this – ask prior to interview)

Session 1 – 'understanding our emotions.' Collaborative construction of formulation, 'old brain' and 'new brain' concepts were discussed, soothing body scan, soothing breathing, talked about idea of this being one version of ourselves (convent vs biker gang).

Session 2 – 'motives and emotions.' Looked at the three systems and how these might apply to you, linked formulation to the three systems, thought about what we feel, act, think, and behave like when in each of these systems. Drew the size of each of your systems relative to each other. Connected to the desire

to show someone else compassion and kindness and what this felt like, also thought about attributes of compassion. We looked at the attributes of compassion and skills required to build these, and started practising the 'compassionate self' and what it feels like to be compassionate towards others. We started to think about why there may be psychological barriers to being self-compassionate.

Session 3 – 'emotions.' Did 'compassionate self' exercise to start building this. Explored barriers to compassionate in more detail and where this might have come from, metaphor of the 'two teachers,' explored challenges to connecting with emotions, did the 'developing the compassionate image' exercise (imagined growing and being wise, strong, kind etc). We focussed on your thoughts, emotions and physical sensations when being self-critical vs feeling compassionate towards someone. I talked about the 'two wolves' and how the intent to be compassionate is important – which wolf did you want to 'feed?' We did the exercise about imagining watching yourself this morning but from a compassionate point of view, and acknowledged this is much more difficult to apply to ourselves but it can be helpful to start by thinking about it 'rationally' on a cognitive level, even if you didn't believe it yet.

Session 4 – 'the different parts of you.' Reflected on when you noticed you were in your different system over past week and what this felt like. We started to look at and discus the 'developing the compassionate self' sheet and what the 'compassionate self' meant to you. Looked at the 'spokes of compassion' and how when the compassionate version of us is used, how this affects what we focus on, think about, feel like, act like etc, and then switched the 'compassionate self' with the 'anxious self' to see and feel the difference, practised what it felt like to show compassion to someone else. I explained the Christmas tree metaphor and that it is normal to feel like the anxious part is like a magnet, but that practise helps until being compassionate is the new habit. We did some more imagery on developing the compassionate-self further.

Session 5 – 'shame and compassion.' We looked at the completed 'developing the compassionate self' sheet and what this meant to you. Talked about

important of making it something/someone relatable and that you wanted to connect with. Kept reflecting back to the formulation and considering compassion as a prescription for emotional wellbeing – e.g. if you don't ask for help because this is seen as bad, what unintended consequences does that result in?, Use of imagery (thinking about food when hungry, someone we care about, someone who is critical) to demonstrate the power of compassion. Talked about existing barriers to being self compassionate, and function of self critic. Talked about how the self-critic can be helpful sometimes, but that it perpetuates the formulation, and that you made a commitment to do things differently. Talked about evidence that self-compassion and self-kindness are associate with wellbeing and being able to cope with life's stresses. We did an imagery exercise on 'compassion flowing out,' particularly to people who it is more difficult to extend to, and for people across the whole world. You described your formulation in a compassionate way, with a new understanding and perspective.

Session 6 – We recapped the sessions and the handouts we have used, and what she has reported has been more helpful or unhelpful. Talked about your short-term and long-term goals for continuing to use the techniques and how you might stay well, particularly for after the baby is born. We considered whether it has helped you understand your problems better by looking at your formulation. Focus on how the intent is important in pursing compassion and mindfulness, and different ways of being mindful. Looked at summary sheet of compassionate attributes and skills, and how these relate to formulation. You were given the 'compassion diary' and further resources sheet.

Change Interview Questions

1. **General experience of therapy and life at the moment.**

1a. How are you at the moment?

1b. What has therapy been like for you?

2. **What changes, if any, have you noticed in yourself since therapy started?**

2a. Are you doing, feeling, or thinking differently from the way you did before? What specific ideas, if any, have you gotten from therapy so far, including ideas about yourself or other people? Have any changes been brought to your attention by other people?)

2b. Has anything changed for the worse for you since therapy started?

2c. Is there anything that you wanted to change that hasn't since therapy started?

3. **Change ratings: Expectedness, likelihood without therapy, and importance of each change (5 point rating scales):**

(Go through each change and rate it on the following three three scales:)

3a. For each change, please rate how much you expected it vs. were surprised by it? (Use this rating scale:)

(1) Very much expected it

(2) Somewhat expected it

(3) Neither expected nor surprised by the change

(4) Somewhat surprised by it

(5) Very much surprised by it

3b. For each change, please rate how likely you think it would have been if you hadn't been in therapy? (Use this rating scale:)

(1) Very unlikely without therapy (clearly would not have happened)

(2) Somewhat unlikely without therapy (probably would not have happened)

(3) Neither likely nor unlikely (no way of telling)

(4) Somewhat likely without therapy (probably would have happened)

(5) Very likely without therapy (clearly would have happened anyway)

3c. How important or significant to you personally do you consider this change to be? (Use this rating scale:)

(1) Not at all important

(2) Slightly important

(3) Moderately important

(4) Very important

(5) Extremely important

4. **Attributions. In general, what do you attribute any changes to?** *In other words, what do you think might have brought them about? (Including things both outside of therapy and in therapy)*

5. **Resources:**

5a. What personal strengths do you think have helped you make use of therapy to deal with your problems? (what you're good at, personal qualities)

5b. What things in your current life situation have helped you make use of therapy to deal with your problems? (family, job, relationships, living arrangements)

6. **Limitations:**

6a. What things about you do you think have made it harder for you to use therapy to deal with your problems? (things about you as a person)

6b. What things in your life situation have made it harder for you to use therapy to deal with your problems? (family, job, relationships, living arrangements)

7. **Helpful aspects.**

What have been the most helpful things about your therapy so far? Ask about whether specific sessions or techniques were helpful/they noticed the most change following.

Then use Helpful Aspects of Therapy Framework to complete with the client for the session or technique named (do more than one if necessary)

8. **Problematic aspects. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you? Was there anything that was difficult or missing from your treatment?**

8a. What kinds of things about the therapy have been hindering, unhelpful, negative or disappointing for you? (For example, general aspects. specific events)

8b. Were there things in the therapy which were difficult or painful but still OK or perhaps helpful? What were they?

8c. Has anything been missing from your therapy? (What would make/have made your therapy more effective or helpful?)

9. Research aspects. What has it been like for you to be involved in this research?

9a. What has it been like to be involved in this research? (Initial screening, research interviews, completing questionnaires etc)

9b. Can you sum up what has been helpful about the research so far? Please give examples.

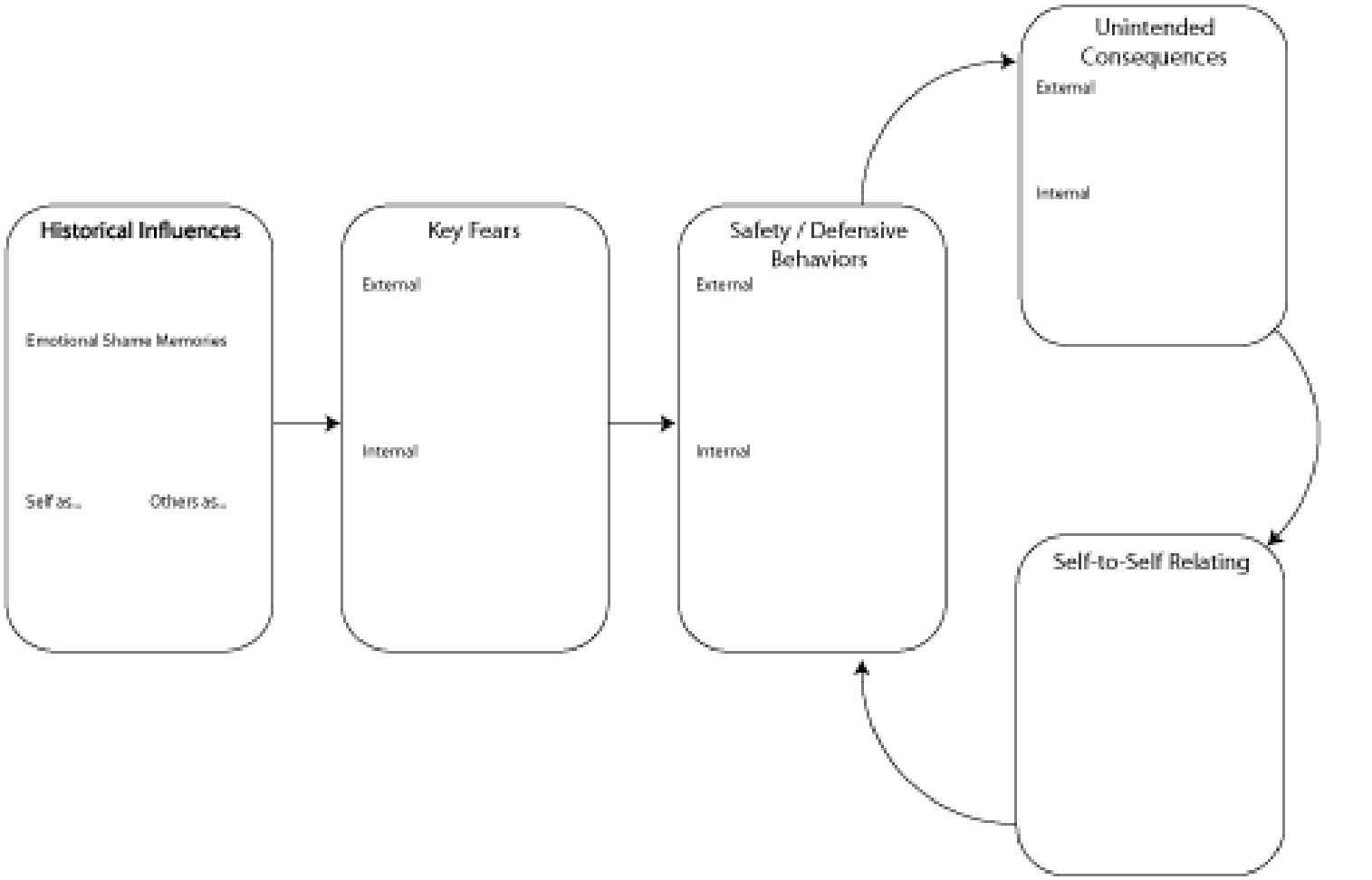
9c. What kinds of things about the research have been hindering, unhelpful, negative or have got in the way of therapy? Please give examples.

10. Other

Do you have any suggestions for us, regarding the research or the therapy? Do you have anything else that you want to tell me?

Appendix K: Blank CFT Formulation

Compassion Formulation



Appendix L: Extracts from reflective journal

Anna

- I realised that it isn't possible (or wasn't with Anna) to construct a formulation between the assessment session and session one. This was because I didn't have enough info from the assessment session and we didn't have enough time in that hour to delve into it. Therefore I included doing the formulation in today's session. This worked out okay today but meant I felt slightly rushed and ended up running nearly 10 minutes over the 1.5 hour slot. I am also a bit worried because Anna said that although she can see how mindfulness can be helpful due to relaxation, she is struggling to see how it will benefit her in terms of her formulation and presenting problem. I had attempted multiple times in the assessment session and today's session to emphasise why it was important, and I explained at the end that we would build on CFT theories/concepts and refer to the formulation to show how it is relevant, but I hope that I can do this effectively and she doesn't drop out. Otherwise, I felt the session went well and I managed to get through pretty much the whole manual without reading too much (i.e. just reading off the paper without looking at her).
- Following the session, my supervisor Katie (specialised clinical psychologist) had received a phone call from Anna saying she was ready to start therapy as she thought it was an 'open appointment' with Katie. This presented an ethical dilemma as I wanted Anna to continue with the intervention both to 'give it a chance' but also as she was the only participant embarking on the project currently. However, Katie and I felt it would be unethical to deny her access to Katie, as she is due to give birth in two-months' time and is concerned about aspects surrounding this time, Katie said that after speaking to Anna, it became clear that starting to talk about these issues with me had encouraged her to want to access further therapy to explore issues which I outlined at the beginning that we wouldn't have chance to discuss. It is interesting to consider whether therefore two sessions of CFT encourages someone to be open

to the idea of therapy and also helped her make connections to previous experiences. However, potentially she also felt CFT wasn't 'enough' at this time to really tackle her prime concerns. This may partially be due to the CFT manual whereby each week we build upon existing concepts to help link to the individual's experiences, and perhaps therefore only two sessions wasn't enough at this point. Although I felt the therapeutic relationship was positive, she potentially didn't agree and wanted a different therapist. In contrary to these theories about her not wanting to continue therapy, she was looking ahead in the diary at the end of this session and saying things like "we might need to change the time in two-weeks' time" which implied a commitment. Katie and I decided the most ethical course of action was for Katie to offer her an appointment when she was able to, and to give Anna the option to continue therapy with me, so she wasn't punished for wanting further therapy with Katie. I would then discuss with my research supervisors whether this data could be used, if she commenced therapy with Katie. However, Katie and I also discussed how although having therapy alongside the intervention may interfere with results/data, so could informal social support from family and friends. A participant may feel more supported be chatting to their mother each week than receiving formal therapy from a psychologist, yet we can't stop this from happening. Perhaps we are over-optimistic and bias in our view of psychology in assuming it would have a large impact on the results.

- At the time I said and felt "let's just keep going and work it out later" – i.e. whether I would be able to use the data. However, a couple days later, I felt lots of anxiety as I became really worried that I would lose my one and only participant. Katie also told me that the team seemingly accidentally misled me and there weren't loads of potential participants. She had also been working through the waiting list and cleared this, so this was no longer an option. We therefore were relying on new patients being referred into the service and on Katie's suggestion I formed an

email to send to the team reminding them of the criteria and that I needed two more participants.

- I am rapidly realising that the manual needs to be a framework rather than going through it like a script. I am adapting it according to the conversation and client's needs at that time. In this way, I think the manual is used how it should be used, according to what will work best for the client, which should also reflect the reality of using CFT as there is no set manual. Additionally, this intervention is more likely to work for the client if we are adapting it for them. Also, the point of doing a HSCED is that it provides a clinically accurate account/data, rather than the generalisability/replicability of RCT's, so although it is helpful to have some sort of replicability and comparison via the manual, I don't want to remove the clinically accurate aspects of adjusting your practise for the client's needs.
- I think the therapeutic relationship is improving when I am more flexible. At times in the session Anna looked more emotional and welled up, so perhaps she is starting to connect with her emotions now, which is what we have focused on. We have focussed on connecting with emotions and body rather than the cognitive and behaviours, as she identified this is a challenge for her. If she is unable to do this, it will be incredibly difficult to truly connect with compassion, which is why I have focused on this more. By following Katie's advice of considering "what is the main point of the session I want to get across?" I think I have relaxed and made the session more meaningful for the client. The office has been unbearably hot across all our sessions and I wonder if this has had a negative impact. I also realise that chair work isn't practical for hot, heavily pregnant ladies!
- I am confused as to whether Anna has truly benefitted from this intervention. She reports potentially only making changes because "she was doing it anyway" but then also talks about noticing when she is doing something differently. Perhaps this is part of her denying her own achievements and admitting she has achieved something, yet she is also

driven by achievement as this is her main incentive. However, she said she is going to pursue further practice of compassion and mindfulness. I think she has mostly connected to the mindfulness, and she did say that this intervention has helped challenge her preconceptions around mindfulness and compassion, to something more relatable and tangible. However, she again said she "sees the words on the page yet they don't mean anything to her." I'm not sure whether this is something I'm doing wrong or if part of her difficulties are that she can't/won't connect emotionally to concepts. However, we discussed how starting with practical steps and connecting on a cognitive level is a valid first step, and that it is the intention which is important.

Claire

- I met Claire for the first time today. She was very different from Anna and certainly seems connected to her emotions, including becoming tearful in the meeting. Claire has never had structured therapy before so this may impact how she responds – either feels it is helpful because at least she is having regular contact with a professional versus not prepared for the amount of exploring and sharing involved, as I don't think this came naturally to her. She found it a little difficult at times to identify thoughts and emotions and make links between these, although I felt she opened up to this and found it easier towards the end of the session. I am worried that she will be unable to commit to attending each session because she started off by saying that she is stressed having to juggle her children's health appointments, finding childcare, and her own midwifery/healthcare appointments. She was very different to my first participant in that she had not had therapy before, which may affect expectations or the way she responds. Just speaking to someone may feel enough for her, whereas Anna would frequently compare CFT to CBT.
- I have realised that it isn't going to possible to ensure every session is 1.5 hours long as some participants need to leave after an hour to pick

kids up from school, and in order to make my heavily pregnant participants comfortable, I am suggesting they take breaks when required. Claire also needs to check her blood sugar during the session due to gestational diabetes so it is impossible to ensure the session runs exactly 1.5 hours. Therefore it will be difficult to be very specific about length of sessions when considering this intervention generally, but perhaps this is simply representative of real world clinical practice, which is what this method aims to do (rather than the strict generalisability of RCTs). Claire said she found the body scan distracting, as did Anna, and found it difficult to focus on her stomach, ribs, and lungs, because she was aware of the baby 'squishing' her and the sensations were unpleasant. This is something important to consider for future as this has never arisen before with patients and seems specific to pregnant women (which seems obvious now but wasn't before). I spent time emphasising the importance of carving out this time to look after herself as she highlighted she does not have any other time for herself the rest of the week.

- In attempting to be flexible with techniques and exercises we use (to suit the client), this is potentially a threat to the research 'stringency' as everyone is receiving the same core message for each session, but I am adapting the focus slightly for each patient and the exercises that works for them as you would in clinical practice. Due to the HSCED method, doing the exact same thing for each participant is less important as we pick apart the nuances of this with the qualitative information, but it would have made it easier and stricter for analysis etc. However this also reflects the nature of CFT where there isn't a set manual or order of things, but is left to the clinician and their clinical judgement which techniques they use and where the focus is, as long as the core components of CFT are addressed.
- I noticed that Claire requires more time and prompts to identify feelings in her body, thoughts, and emotions, but that may be reflective of the fact she hasn't had therapy before.

- It was encouraging to hear Claire connecting to the concepts and making her own insights and links to things, as this seemed quite alien to her in the previous two sessions. I've noticed that I am better at my time-keeping and I think the third session I do is the strongest in terms of my confidence and knowing which bits to emphasise or spend more time on (i.e. the third time I do 'session two') so it'll be interesting to see if the scores reflect this.
- I realised there is no point doing the chair work with heavily pregnant women, so we have been using this in a less formal way by me constantly asking "what would anxious self say about that" followed by "how would self-critic/'compassionate self 'respond" which seems to work better.
- I think with Claire simply being able to talk about and explore painful things will be a huge thing for her as she says she never does this, alongside never making time for herself due to competing demands.

Ruby

- I felt like I immediately connected with Ruby. She seemed bubbly and friendly and open. I was treading carefully as she was apparently very sensitive about staying completely away from the past and trauma, which she also raised in the session. However, she surprised me by bringing up the trauma herself and how she felt. She referenced feeling out of control and untrustworthy of professionals, and alluded to physical health complications as a result. Ruby said she was looking forward to the therapy and felt it would really help. I was conscious of the fact that the sessions (for all participants) take place in a very un-therapeutic doctors room, which contains equipment, an examination bed etc. I was worried it might distract and trigger Ruby but she did not appear to be distressed by this. I was surprised that she was bubbly and outgoing and humorous as I had an image in my head of her being introverted and meek given

the high level of protection the perinatal team had around her and the way they spoke about her to me, which is interesting.

- I was worried about Ruby finding the mindfulness exercises triggering and distressing, as this can happen with people who have experienced PTSD, but she really connected to both of them. I think this is partially because she has been doing some relaxation exercises with other members of the perinatal team. Therefore I spent time differentiating between relaxation and mindfulness, whilst acknowledging that they compliment each other and can both be done (if the aim is clear). I feel like I can identify with her, so I need to be aware that I don't make assumptions about her experiences or make it too much about me. I have been aware of giving more of my own examples with Ruby and Claire in an effort to help the therapeutic relationships and make the concepts more tangible, as this is something Anna struggled with but found examples helpful. Ruby referenced the traumatic birth and fears around this, which I attempted to contain whilst preventing giving her the message it was something to be completely avoided. This is quite a tricky balance because as a therapist I want to explore the trauma when she is willing to, but I need to be aware of the CFT intervention and protocol, and appropriately containing this whilst not dissuading her.
- Ruby reported that the exercises have been helpful for her, and seemed to really connect to the concepts. I noticed she has been using CFT language when explaining how she feels or events which have happened, which is really encouraging.
- Ruby came up with her own idea for using her compassionate self by writing down some thoughts and challenging them, and is going to do this before next week. I found this really encouraging and positive. After talking to Katie about how Ruby seems to be responding to the intervention, Katie and I were hopeful this will really help her and this has surprised the team as prior to commencement of the intervention they were very protective over Ruby and viewed her as fragile and vulnerable.

The team voiced anxieties that therapy could have worsened her distress and ‘pushed her over the edge.’

- I was pleasantly surprised at the effectiveness reported by Ruby with her PTSD symptoms as this is not something which was expected to be targeted by the intervention. Maybe this highlights that this intervention is potentially an effective way to help someone feel safe and stable enough before doing trauma work, as Ruby had previously felt unable to do this. However, Ruby told me in our last session that she did not feel that she required further therapy due to the reduction in her symptoms and expectation this would further reduce after the birth was “over with.”.

Thesis Poster

Is CFT an effective intervention for antenatal women with mental health difficulties? A HSCED design.

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Background

- Early detection and treatment of antenatal mental health difficulties (MHD) are critical in ensuring the welfare of the woman and infant.[1]
- Guilt and shame are particularly high in perinatal women[2].
- Guilt and shame can worsen symptoms of distress due to feeling unable to disclose symptoms and seek support.[3]
- Compassion-Focused Therapy (CFT) is an integrated therapeutic model which emphasises affect regulation systems[4] and attachment principles[5] which is particularly important for the mother-infant relationship[6].
- CFT aims to target compassion, guilt, and shame to reduce distress.

Method

- Three pregnant participants with antenatal MHD.
- Six-week individual CFT intervention.

1 Gather data

- Quantitative outcome and CFT process measures
- Change interview
- Therapist notes

2 Form rich case records

- Data reviewed and affirmative and sceptic cases formed for each participant: Did client make meaningful change? Was change due to therapy? Was change due to CFT-specific processes?

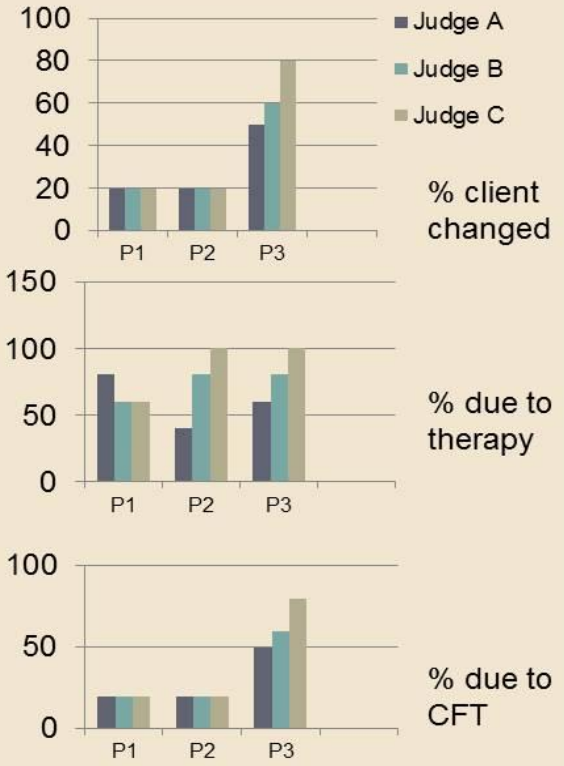
3 Adjudication

- Three judges of differing theoretical orientations reviewed rich case records
- Judges reported their opinions on each of the 3 research aims, for each participant

Conclusion

Overall effectiveness was inconclusive. Changes were mostly due to therapy. Generic factors were key: mindfulness, formulation, psychoeducation and therapist attributes.

Results



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